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# SOUTHERN PRACTITIONER

AN INDEPENDENT MONTHLY JOURNAL

DEVOTED TO MEDICINE AND SURGERY

NASHVILLE, TENNESSEE

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EDITOR AND PROPRIETOR

DEERING J. ROBERTS, M. D.

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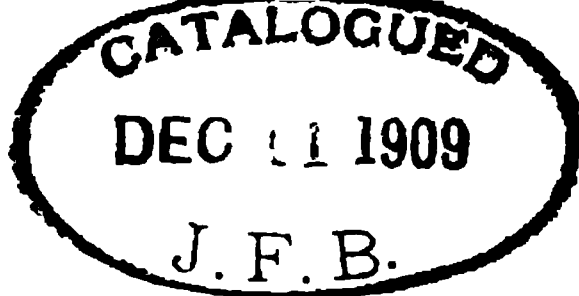
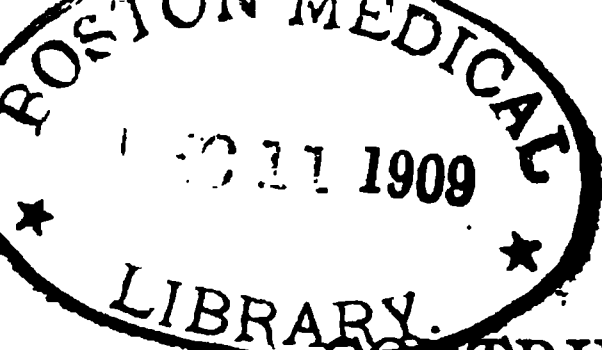
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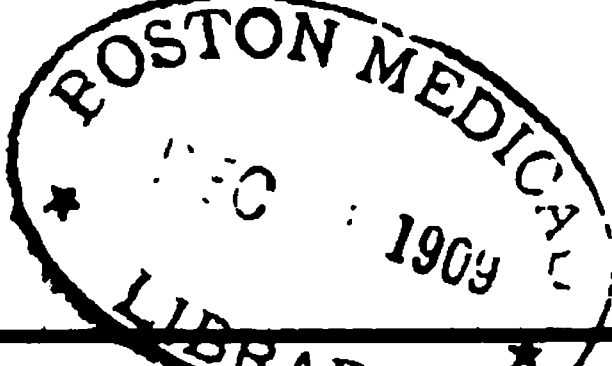
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### *Original Communications.*

DO WE PLACE TOO HIGH A VALUE ON THE PRESENCE OR ABSENCE OF MURMURS IN CARDIAC DISEASE? \*

BY E. G. WOOD, M.D.,

Professor of Practice of Medicine and Clinical Medicine in the Medical Department of the University of Nashville.

To the average medical student a cardiac murmur possesses a peculiar and fascinating interest. Entering the hospital ward, armed with his stethoscope, he rushes with undisguised satisfaction to the "new heart case" that has been admitted, and if he can discover and accurately locate a murmur, he is eminently pleased with himself and his diagnostic powers. In too many instances he entirely ignores the information to be gained by the symptoms and by inspection, palpation, and percussion, and promptly proceeds with auscul-

\* Read at meeting of the Nashville Academy of Medicine, Tuesday, Dec. 1, 1903.

tation. If there is no murmur, his verdict is that all is well and there is no organic disease. If, on the other hand, a murmur is heard, the victim is at once condemned to the dangers of serious heart disease, if not to an early death. Even auscultation is incomplete, for, satisfied with the presence or absence of a murmur, he pays little or no attention to the character of the normal sounds, notwithstanding that the quality and intensity of the latter are often of much greater importance than the existence or nonexistence of the former. Too often he learns, only after long and perhaps humiliating experience, that a man may live a long and active life with no sign or symptom of disease save a blowing sound in his cardiac area; or, on the other hand, that his patient, who presented no murmur and whom he has pronounced free from organic disease, suddenly succumbs to "heart failure." After such experience he begins to question the infallibility of the one sign upon which he had placed so much reliance both in the diagnosis and prognosis of cardiac disease.

Turning now to the evidence afforded by the symptoms and by other methods of examination, he soon realizes that the information thus obtained is in many cases of far greater value than the presence or absence of a murmur, and that the true significance of the latter can be estimated only when considered in connection with the former.

The object of this paper is to show that with many of us there is still a tendency to overestimate the value of a murmur and to minimize the significance of other signs of disease in the heart; to show also that in many grave cardiac conditions a murmur may be the least valuable of all the signs present both in diagnosis and prognosis.

The relative value of murmurs to other physical signs of cardiac disease may be considered in regard to (1) diagnosis, (2) prognosis.

I. *Diagnosis.* *The detection of a murmur in the cardiac region is not conclusive evidence of disease of the heart.* Excluding pericardial or pleuro-pericardial friction sounds, vascular murmurs, and the murmur of aortic aneurism, murmurs in the cardiac area may be hæmic, cardio-respiratory, or organic. Hæmic and cardio-pulmonary murmurs, which are nearly always systolic, but may, as Cabot, Locke, and others have shown, be rarely diastolic,

are so common that a systolic murmur anywhere in the cardiac area must always be regarded with doubt in the absence of other signs of heart disease. If careful examination by inspection, palpation, and percussion, and attention to the character and relative intensity of the heart sounds, fail to show any sign of cardiac disease, the greatest doubt must exist as to the endocardial origin of a murmur that may be present. On this point Cabot says: "Perhaps the majority of all murmurs are unassociated with valvular disease."

Medical examiners for life insurance companies frequently meet with men whose personal history is clean, but who present systolic murmurs in the cardiac region. Interrogation fails to elicit any symptom of disease, and careful examination fails to discover any enlargement of the heart or any change in the character or intensity of its sounds. Yet, though these men swell the great army of "the rejected of life insurance companies," they often live in perfect health to a ripe old age and never show any symptom of cardiac disease. Possibly in some of these cases there is a small leak through the mitral orifice which is perfectly compensated by a vigorous and well-nourished heart, but no doubt in many of them the murmur is a cardio-respiratory one, and therefore of no serious significance.

Murmurs of endocardial origin may be produced by an incompetent or stenotic valve opening, by the passage of the current of blood over the roughened surface of the valve segments (Chauveau), or by relative obstruction at a cardiac orifice, as when the aortic ring and its valves are normal but the conus arteriosus is dilated. But a true organic murmur in itself furnishes us with very limited information, and may entirely mislead us at a time when an accurate diagnosis is important. For example, in acute articular rheumatism the detection of a murmur at the first examination naturally raises the question as to whether it is due to recent or old endocarditis, but fails to answer it. Unless it changes its character and extent from day to day, the question can be solved only by the past history and by attention to the secondary physical signs, the discovery of increased cardiac dullness with an accentuated pulmonary second sound indicating changes of some duration. It must not be forgotten that in acute rheumatism, as in other acute diseases, a functional or hæmic murmur may be heard

and disappear with recovery. Hence the presence of a murmur alone even in a case of acute articular rheumatism is not sufficient evidence of acute endocarditis.

Even in well-marked valvular lesions a murmur is only a confirmatory sign. In aortic regurgitation the collapsing pulse, the dancing arteries, with the enormously hypertrophied left ventricle and loud first sound, point almost unerringly to the incompetent aortic valves, and the diastolic murmur but confirms the diagnosis already made. In mitral regurgitation the small, weak pulse out of proportion to the rather forcible ventricular impulse at once suggests a leak, and if associated with it are increased transverse cardiac dullness, an accentuated pulmonary second sound, with dyspnoea on exertion and an enlarged liver, surely the detection of a murmur is unnecessary to a diagnosis.

A systolic murmur is frequently heard at the base of the heart, but its significance cannot be estimated in the absence of other signs. It naturally calls to one's mind aortic stenosis, but it is well known that uncomplicated stenosis at the aortic orifice is very rare, and Osler states that not over one per cent of basic systolic murmurs are due to this lesion. Such a murmur may be due to a roughened atheromatous aorta, to dilatation of the aorta, or to anaemia, or it may be cardio-respiratory. The value of this murmur by itself is therefore very limited in diagnosis.

Even when the murmur is so typical as to be characteristic of a particular lesion, as in aortic regurgitation, mitral stenosis, and in some cases of mitral regurgitation, it gives us little or no information as to the condition of the cardiac muscle and the degree of compensation, and this information, which is usually the most valuable in the case, can be obtained only by attention to the symptoms and secondary physical signs.

*The absence of a murmur is not conclusive evidence that the heart is sound.* In some of the gravest disorders of the heart murmurs may be absent at times or throughout the whole course of the disease.

1. Murmurs, though usually present, may at times be absent. Probably no murmur has a greater diagnostic significance than a well-marked presystolic. As long as the power of the auricular wall is good and the tension in the pulmonary veins normal, this murmur is distinct and the diagnosis clear, but when the wall of



the auricle fails, its contraction may be so feeble that the murmur becomes inaudible.

Again, in mitral regurgitation, when the wall of the left ventricle becomes so weak that the blood is not driven back through the mitral orifice with sufficient force to produce an audible sound, the murmur disappears, and if such a heart be now examined for the first time, the diagnosis must rest entirely on the other signs and symptoms. So accustomed are we to hear a mitral regurgitant murmur in mitral incompetence that, unless we realize that its absence does not negative such a lesion, we must utterly fail to recognize the true condition in such a case.

2. The absence of murmurs in grave disorders of the heart. A murmur may be absent throughout the entire course of an attack of acute endocarditis, in the malignant as well as in the simple form. It has been previously shown that the discovery of a murmur during an attack of acute rheumatism does not necessarily indicate acute endocarditis, as it may be accidental or due to an old lesion; hence the diagnosis of acute endocarditis cannot be made from the presence of a murmur alone, nor can it be excluded if no murmur be heard.

Angina pectoris is probably the most dangerous of all cardiac disorders, yet it is not directly associated with a murmur, which is, indeed, usually absent. True, a basic murmur is not infrequent, and though its presence would strengthen the diagnosis, it may be only an accidental phenomenon, and does not necessarily indicate that the anginoid attacks are the result of the condition that produces the murmur. With a history of an attack of true angina, with the characteristic sternocardiac pain and heart anguish, especially if it be associated with signs of stiff arteries, sclerosis of the aorta, dilatation of the heart, or a ringing aortic second sound, no physician would think of declaring the heart normal because no murmur could be heard. In fact, cases of true angina pectoris are occasionally met with in which no signs of cardiac or arterial disease can be discovered, and the diagnosis must rest solely on the subjective symptoms of the attack.

Another grave heart lesion in which murmurs are often absent is chronic myocarditis. Though myocardial degeneration (fatty or fibroid) is easily recognized by the pathologist, it may be entirely overlooked during life. Latent in some instances up to a fatal

termination, it may in others manifest itself in symptoms so vague and indefinite that the true nature of the malady may not even be suspected. Insomnia, with restlessness at night, nervousness, indefinite sensations in the precordial region, sighing, numbness, belching, etc., are common in chronic myocarditis, and if no murmur is heard are usually attributed to gastric disorder, or the patient is said to have a nervous heart. In more marked cases one may get a history of precordial anxiety, if not actual pain, of consciousness of the heart's action and cardiac irregularity which is usually aggravated by exertion. If such symptoms are unassociated with a murmur or signs of enlargement of the heart, they are often attributed to gastric irritability or to the abuse of tobacco or alcohol. But, though a careful examination of the heart fails to discover either murmur or increased dullness, we often find a feeble and diffuse cardiac impulse, with a weak and imperceptible apex beat. The first sound is feeble, perhaps short, closely resembling the second, and may be heard more distinctly over the right ventricle than over the left; the aortic second sound may be accentuated and the arteries may be palpable while the pulse is small and weak, perhaps irregular and intermittent. When a man past forty complains of the above symptoms, myocardial weakness should at least be suspected; and if associated with these symptoms there are a feeble apex beat and a weak first sound, myocardial change may safely be diagnosticated. In such a case "it is not so much the detection of an actual murmur that is significant as is the recognition of changes in the character and relative intensity of the cardiac sounds." (Babcock.) Balfour (Senile Heart) says: "It may be accepted as an axiom that all cardiac symptoms complained of after middle life, that cannot be distinctly referred to some evident disease, or to some affection of the cardiac mechanism due to disease, may be regarded as originating in actual or relative weakness of the myocardium."

Though relative mitral incompetence with a systolic apical murmur develops when the myocardium has given way and considerable dilatation has supervened, many cases terminate fatally before this stage is reached.

A man of fifty-six, actively engaged in business, was rather short-winded on exertion, felt an ill-defined sense of discomfort in his chest, was occasionally nauseated and weak without effort. His

face was pale, his pulse was small, compressible, irregular in force, and its weakness became more marked on elevation of the arm. Physical examination revealed no sign of cardiac disease save a feeble cardiac impulse and a weak, tapping first sound; there was no murmur. With such a history in a man of fifty-six, how much more significant were the feeble pulse and cardiac impulse, with a weak first sound, than the presence of a murmur! Though urged to take complete rest in bed, this man conducted his business as usual, and a few days later dropped dead on the street while waiting for a car.

A man of sixty-three suffered from a fairly well-marked attack of angina pectoris. After the paroxysm he was apprehensive, his pulse was weak, the cardiac dullness was increased both to the right and left, the first sound was weak and the aortic second sound accentuated; but there was no murmur. He was kept in bed, but one week later suddenly developed pain in the right chest with rapid breathing, hæmoptysis, and subnormal temperature. The heart's action was exceedingly rapid and tumultuous, and beneath the right scapula crepitant rales were heard over a small area. A few days later he died suddenly from a similar attack in which cyanosis was a marked feature. His condition was attributed to pulmonary embolism, probably due to a dislodged thrombus from the right auricle.

Both cases illustrate not only the value of the symptoms and secondary physical signs in disease of the heart, but also the occurrence of most serious cardiac lesions in which no murmur can be discovered. Doubtless many cases of myocarditis are entirely overlooked because, on a hurried and superficial examination, no murmur can be detected; yet attention to the extent of the cardiac dullness, to the pulse, and to the character and intensity of the heart sounds would lead to a prompt recognition of cardiac weakness and prevent the error of calling these cases of reflex, nervous, or tobacco hearts. One has been struck with the very superficial examination that is often made by the physician when asked if the patient can safely take an anæsthetic. He places his ear somewhere over the cardiac region, often without removing the clothing, and if he hears no murmur, at once declares that the heart is sound. It is obvious that an opinion based on such a superficial and inadequate examination is of very limited value indeed.

When a murmur is certainly of endocardial origin, it possesses a positive value in diagnosis that cannot be ignored, but unless it be considered in connection with other physical signs, its diagnostic value is decidedly limited, and if taken by itself even its endocardial origin must frequently be in doubt. As Cabot says, "No diagnosis is satisfactory which rests on the evidence of murmurs alone."

From the foregoing remarks on the diagnostic value of murmurs, it may reasonably be concluded:

1. That a murmur in the cardiac area is not conclusive evidence of disease of the heart, inasmuch as it may be hæmic or exocardial in origin.

2. That if undoubtedly endocardial in itself, it gives little or no information as to the condition of the cardiac muscle and often very little information as to the extent of the valvular lesion.

3. That in most cases changes in the size of the heart, the character and relative intensity of the cardiac sounds, and the condition of the pulmonary or peripheral circulation are the most important factors in the case.

4. That the absence of a murmur has a very limited value in excluding cardiac disease, as in many grave disorders of the heart it may be absent throughout or for a long period.

II. *The value of murmurs in prognosis.* In determining the prognosis murmurs as a rule possess very little value apart from changes in their character or intensity or the development of new ones during the progress of a case. It has been already remarked that an individual may present a murmur as the only sign of disability through a long and healthy life, and it is the experience of every physician that during an attack of acute rheumatism in early life a patient may develop endocarditis which leaves him with a permanently crippled heart as evidenced by a loud blowing murmur, but enjoy complete freedom from symptoms for many years to come. With such experience we are bound to realize that a murmur does not enable us to form an opinion as to the gravity of the case. Neither is the gravity of a valvular lesion proportionate to the intensity of the murmur. Indeed, it may be stated as a general rule, to which, however, there are many exceptions, that the louder the murmur the better the prognosis, and the fainter the sound the more gloomy the outlook. A powerful ventricle, in full compensation, may drive the blood through a narrow chink with force sufficient to cause a murmur of such intensity that it may even

be heard at some distance from the chest, while in a weak, flabby heart with a large opening, the sound produced may be so soft and low as to be heard with the greatest difficulty. If a murmur has been present and disappears coincidently with the development of decided symptoms of failing compensation, such disappearance is of grave omen, as it indicates very serious failure in muscular power, while its return under rest and the administration of cardiac tonics indicates increased power of ventricular contraction and is therefore a favorable sign. In such an instance its absence, rather than its presence, is unfavorable. It is just in such cases as these that the secondary physical signs are valuable. Increasing hepatic dullness, rales at the bases of the lungs, a diffuse cardiac impulse, with a weakening first sound and widening dullness, are signs of the gravest import.

In forming our prognosis in a given case we must rely on the general appearance of the patient, his expression, the condition of his pulmonary and peripheral circulation, the size of his heart, and the character of its sounds. Any murmur that may be present will probably supply no information of value.

In pointing out the limitations to the significance of murmurs in disease of the heart, I do not desire to underestimate their true value. I fear, however, that in the presence of a murmur in the cardiac area there is a tendency in many of us to jump to the conclusion that the patient has organic disease of the heart. It has been shown that from the presence of a murmur alone no diagnosis of cardiac disease can be satisfactory. The recognition of this fact is all-important and may prevent an unfortunate mistake, for it must be admitted that it is particularly unfortunate to tell a nervous patient that he or she has heart disease when in reality that organ is quite sound; and where there is in the mind of the practitioner a reasonable doubt as to the organic or functional origin of the murmur, it is certainly wiser to give the patient the benefit of the doubt, at least until its true character can be established.

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**PRIZE ESSAYS.**—The Maltine Company, Eighth Avenue, Eighteenth and Nineteenth Streets, Brooklyn, N. Y., now have ready the two essays on "Preventive Medicine," to which were awarded the prizes of \$1,000 and \$500, respectively. They are bound in permanent book form, and will be sent to any physician free of charge who will make the request by letter.

## FRACTURES OF THE SKULL.\*

BY PAUL F. EVE, M.D.,

Professor of Surgery and Clinical Surgery, and Dean of the Faculty of the Medical Department of the University of Tennessee.

In presenting this brief paper to the Academy, I shall restrict my remarks to the treatment of fractures of the skull, with a report of a few cases which it has been my privilege to treat both in hospital and private practice.

It is not my purpose to enter into the diagnosis of such fractures, yet, in passing, I should like to call attention to those injuries of the head with undefined symptoms and where fractures seem probably to exist, but on account of no external wound cannot have their true character revealed. In such cases I think the surgeon is fully justified in cutting down over the seat of the injury and thoroughly informing himself of the true conditions as they exist. My reasons for this measure can readily be understood when not a few cases with conditions of this kind and where fracture did occur, coming under the observation of some surgeons, have developed epilepsy from pressure upon the brain or formed abscesses which have either been relieved later by an operation or a fatal termination occurred.

I shall commence with treatment of fractures at the vertex of the skull: First, those cases in which there is no external wound, but which by the ordinary objective and subjective signs of fracture are easily discerned. It matters not whether these fractures are lineal, cleft, or multiple, or whether they involve one or both tables, it has been my invariable rule, when not sufficiently satisfied as to such fractures, to cut down over the injury and, if found, to perform the operation of trephining. My reason for so doing is that I believe this is the only adequate measure to properly reach such troubles, and thus ward off symptoms which may subsequently present themselves. In not a few cases which have been sent to me, and where fracture has been discovered by the attending physician, epileptiform seizures have occurred, and by prompt operation for the removal of a disk for relieving this depression of the

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\*Read at meeting of the Nashville Academy of Medicine, Tuesday, Nov. 24, 1903



skull all such symptoms have subsided. I am aware that, not only in some works on surgery but among some eminent men in our profession, advice has been given that in some of these cases, where but little or no symptoms present themselves, the patient should be let alone and watched, and should any symptoms afterwards develop then surgical interference should occur.

I ask in this connection: Why should this be done, when it is a known fact that in many cases subsequent symptoms do frequently exist, much to the injury and discomfort of the patient, and where, under the régime of antiseptic surgery, the operation can be performed with but comparatively little danger? In compound fracture at the vault of the skull we all agree that there is but one line of treatment—namely, the elevation of the bones, or the operation of trephining. I especially desire to give emphasis to the treatment of those fractures in which the dura mater is involved, and where there is an escape of more or less brain substance. The death rate, as we know, in such injuries is very great, although not near so great as it was before the era of antiseptic surgery. The vast majority of deaths which occur in such injuries I believe are due not only to hemorrhage and shock, but also to sepsis, and consequently the greatest care and pains should be taken to thoroughly remove not only every loose bone or fragment but also every ounce of infection.

I am reminded of one of the most extensive fractures of the vault of the cranium that it has ever been my pleasure to have treated, and which occurred some eight or ten years ago, the treatment having been conducted at the City Hospital. The fracture involved a space of four and a half by three and a half inches, involving portions of the frontal, parietal, and occipital bones. The dura mater was lacerated and torn into shreds almost along the whole extent of the fracture, there was loss of brain tissue, and into the wound a considerable amount of cinders had gathered (the man having been thrown on a portion of ground covered with cinders). After combating shock, elevating the depressed portions of bones, and removing the shreds, tissues, and cinders as far as possible, I turned my attention to cleansing every portion of the wound, together with what remained of the dura mater, fully realizing that if sepsis occurred (and there was every probability of its doing so) my patient would inevitably succumb to his injury. I there-

fore determined upon heroic measures, and applied with a nail brush soapsuds, and continued to rub the part until I was satisfied that I had it perfectly clean. I next irrigated the portion of brain which had been injured by spiculæ of bones driven into it with sterilized water at a temperature of one hundred and twenty degrees, and continued this irrigation for ten or fifteen minutes. After this irrigation, a light gauze pack was placed in the wound, both for the purpose of controlling some hemorrhage which still continued and also for drainage. Although my patient was profoundly shocked and continued in this condition for twenty-four hours, I had the satisfaction of seeing him make an uninterrupted recovery, without a drop of pus appearing at any dressing.

I recall another case which has recently come under my observation, and was kindly sent me by Dr. J. W. Maddin, Sr., who treated the case in conjunction with me. A young man, twenty-four years of age, of fairly good health, had received an injury on the back of his head (at the right side) by being struck with a large piece of iron. The fracture was a compound one, the dura mater being literally torn into shreds so that it could not be detected. At the seat of the wound some brain substance had escaped, and he lost a considerable amount more during the operation. The bones were elevated, and a large spicula was found to have passed about an inch and a half into the brain substance. Upon removing this spicula, quite an excessive hemorrhage occurred; and with a view of both arresting the hemorrhage and also to remove any cause for sepsis, the wound was irrigated with a normal hot saline solution, at a temperature of one hundred and twenty degrees. The patient stood the operation fairly well, and for fourteen days no suppuration was discovered, he being allowed to return home at that time, the only symptoms developing during this time being some hallucinations, which, however, passed away, the wound giving every promise of rapid healing. Four weeks after the operation a little pus was discovered coming from the bottom of the wound, and continued to discharge every now and then for a month and a half. Thinking after this time that this was probably due to diseased bone, with his consent I performed a second operation, when, to my surprise, instead of finding any trouble at the bone, I discovered a large abscess in the brain about an inch and a half long and three-quarters of an inch wide. This abscess was evacuated and drained, and the

patient is now on a fair road to recovery. I consider this case as one of secondary, and not primary, infection. I shall burden you with a report of only two other cases before drawing my conclusions. They are as follows: The first was an engineer on the N., C., & St. Louis Ry., who, while in the discharge of his duty, happened to place his head too far out of the cab window of the engine, and was struck in the forehead by a mail crane. After his injury, he continued his run from near Kingston Springs to this city. When he arrived, he walked from the depot to my office, and when questioned, stated that he believed that he had broken some bones of his head, but did not feel any bad effects from them. The patient was removed to the infirmary for treatment, and an examination revealed a compound fracture of the frontal bone above the orbit, which led into the frontal sinus; the dura mater was lacerated, but not punctured. After elevating these depressed bones, the wound was thoroughly irrigated with a normal saline solution at a temperature of one hundred and twenty degrees, and the frontal sinus packed. Not a drop of pus was seen during any of the dressings, and the patient made an uneventful recovery.

My second case was brought to me by Dr. Goodwin, of West Nashville. He received an injury of the skull by being struck upon the left side of the head with a large lump of coal. He seemed to complain but little of his injury, and although the Doctor had detected a compound fracture of both bones of the skull, he was enabled to bring him on the street car from his home in West Nashville to my office, when he was afterwards removed to the infirmary. No symptoms of any character developed until the patient was being prepared for operation, when he was seized by several convulsions of an epileptiform character. The bones were elevated, the dura mater found intact with only a slight laceration, and a normal saline solution at a temperature of one hundred and twenty degrees was used to irrigate the wound. No symptoms of pus ever showed themselves, and the patient was enabled to be removed to his home on the twelfth day, the wound healing kindly, with a complete recovery.

From the above remarks, and also the cases cited, I draw the following conclusions:

First, that in all cases of injury to the vault of the cranium, and where suspicion of any kind would lead to a belief of fracture, or

where there is any doubt, it is the duty of every surgeon, even in cases where there is no external wound, to cut down and thoroughly investigate the seat of the injury. Should there be a small external wound, this should be enlarged and careful inspection made. If there is a fracture of the skull, whether lineal or otherwise, the operation of trephining should be performed at as early a date as possible.

Secondly, on account of the number of cases which have proved fatal from sepsis, I think a thorough irrigation with a normal saline solution should be used, this irrigation to continue from ten to twenty minutes, and where spiculæ of bone are driven into the brain tissue, this irrigation should be carried to the very bottom of such wounds.

And lastly, there should always be drainage, either by catgut, gauze, or tube; and should no pus present itself at the end of the third day, this drainage can be dispensed with. Should there be hemorrhage, it should be arrested, either by a normal saline solution at a temperature of one hundred and twenty degrees, or by a light gauze pack.

In the treatment of fractures at the base of the skull (as many of these fatalities occur from sepsis), I believe they can to some extent be prevented by a thorough irrigation with a warm normal saline solution, say at a temperature of from one hundred and fifteen to one hundred and twenty degrees. This irrigation should be placed either in the nasal cavity or the ear—the hemorrhage which occurs in such cases being at these points, where bacteria usually gain entrance. It has been my plan of treatment for some years, when I meet with such injuries, to irrigate as far into these cavities as I possibly can, and to continue this irrigation from ten to twenty minutes. After irrigating, a small gauze pack is inserted into the nasal cavity or ear, and a cotton pledget placed over this gauze, so as to keep infection from without. It is unnecessary to say that in all such cases strychnia should be administered for combating shock, and bromides with a view to place the brain as it were in a splint. The salt of bromide which I most frequently rely upon is the bromide of ammonium, as I have found better results in its administration. In some few cases I have been compelled to give opium. The form of this drug which I most rely upon, and which I believe give the least objections, is either hypodermic injection

of codeine or heroin. I place great stress upon the position of my patients, having those who have fractures at the anterior fossæ lie almost upon the abdomen, while those with fractures of the middle or posterior fossæ lie upon the ear from which the bleeding occurs. The irrigation in these cases should be done every two or three hours, and be conducted as gently as possible.

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## THE FINSEN LIGHT CURE.

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BY H. JOHN STEWART, M.D., CHICAGO, ILL.

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Having read and heard so much about the Finsen light treatment in the cure of disease, I decided in April of this year to make a personal investigation to see and learn for myself if it were true that such diseases as lupus and rodent ulcer could be cured by light. I visited several institutions where the Finsen lamp was in operation. In Manchester, England, in the Salford Skin Hospital, they had a Finsen Light Department under the supervision of Prof. Brooke, who informed me they were unable to treat half the sufferers who applied for treatment, and they had solicited by public subscription \$125,000 for the erection of a new hospital for skin diseases, where they would be able to enlarge the "light department" so that at least two hundred people could be treated daily, as there were people on their waiting list whom they would be unable to treat with their present facilities for an indefinite time. Prof. Brooke was most enthusiastic over the wonderful results they were obtaining there.

I next visited the London General Hospital, of London, England, and found they were just completing an immense light department, that had been established by the present Queen of England, then Princess of Wales, in 1900, who presented the first lamp at that time, and as it was found to be far too inadequate, she had just given a second lamp, and Alfred Harmsworth had also given \$50,000 for the perpetual endowment of another Finsen lamp in this department, and they were then building a platform to receive the king and queen, whom they expected to come June 1 to dedicate this new department. And even with these increased facilities, I was informed by Prof. Squirey that there were patients on the waiting list who were unable to receive treatment.

I next visited the Light Institute at Copenhagen, and found that all the statements that had been made regarding it were not in the least exaggerated. I had the pleasure of meeting and studying under Prof. Finsen himself, and was extended every courtesy by him and his assistants at this institution. He seemed very much pleased to describe in the minutest detail the apparatus, treatment, etc., and gave me a detailed history of the lamp.

The Finsen light is a large specially constructed arc lamp of twenty thousand candle power, or twenty times stronger than an ordinary street lamp, and uses from sixty to eighty amperes of current. This lamp burns a specially made carbon, which can be procured only at Copenhagen. In the upper holder is a large carbon, while a smaller one is used in the bottom holder. When properly adjusted for arcing a maximum number of violet and ultra violet rays are produced. The advantage of the Finsen lamp over others, is in the greater number of violet rays produced. The Finsen lamp produces a much greater number of chemical rays than sunlight, as the atmosphere absorbs a large percentage of these rays. The light is so intense it is impossible to look at it with the naked eye, and it is necessary for all the attendants and patients to wear dense smoked glasses while the lamp is in operation. An aluminum hood about two feet wide surrounds the lamp, which hood is fringed on its lower border with a deep crimson-colored paper skirt to further aid in excluding the diffused light from the patients.

The concentrated rays are carried from the arc to the patients through four telescopic tubes, known as converging tubes, suspended at an angle of forty-five degrees, the tubes containing a series of rock crystal lenses so arranged that reservoirs for running water exist between them. By means of the water screen and rock crystal lenses, all rays but the violet are eliminated, and these rays are converged and concentrated, thus vastly increasing the healing and bactericidal effects.

The heat from the original arc is so intense that, to prevent cracking of the lenses and discomfort to the patients, a stream of cold water is kept constantly circulating through the reservoirs or water screens.

To further concentrate and cool the rays, a compressor is provided which consists of two rock crystal lenses so arranged that a chamber for running water exists between them. This part of the apparatus is used to compress the affected area and make it blood-



less during the treatment, thus facilitating deeper penetration. The Finsen arc light has been used with marked success in curing many skin diseases, thought until this time incurable, especially lupus and rodent ulcer. During a period of six years the Finsen Medical Light Institute at Copenhagen has grown from a very small shed, where they were able to treat only one patient at a time, to a magnificent institution where they are now treating three hundred people daily, and light institutes have been established in London, England, St. Petersburg, Russia, Paris, France, and Chicago, Ill., where they are all carrying on a similar work to the parent institution.

It has been a popular belief that lupus was a very rare disease and common only in the northern countries, and although it was supposed there was no lupus in London, the hospitals are now treating one hundred and seventy-five cases daily, and the management was compelled to install two more lamps and build a separate department, so great has been the demand from people seeking relief. Lupus was considered very rare in the United States, but since the establishment of the Finsen Light Institute in Chicago the author is informed they have been taxed to their utmost capacity, and they, too, have found it necessary to increase their facilities, as there are now patients on the waiting list who are not able to receive treatment. It seems but a question of a short time until light institutes will be established in every large city in America, because it has proven so efficacious in many other skin diseases besides lupus and rodent ulcer, such as acne, alopecia areata, localized eczema, chronic ulcers, and nævus. The treatments are given while the patients recline on couches. By firm pressure with the compressors on the tissue to be treated, the blood is removed and more heat can be borne and deeper penetration produced. This compression has another important advantage in that the bactericidal effect is greater because it has been shown that the corpuscles absorb a considerable portion of the rays, and thus prevent deep penetration.

The affected area is placed about ten inches from the distal end of the converging apparatus, and the treatments (or seances, as they are called) take about one hour daily in lupus and rodent ulcer, and in other skin diseases from ten to twenty minutes, depending upon each individual case.

The results attained have been hardly less than marvelous, since from carefully compiled statistics, covering a series of over eight hundred cases of lupus treated at the Finsen Institute, an overwhelming percentage of cures and an insignificant number of failures is shown, and Prof. Finsen goes so far as to say that in lupus vulgaris cures can be obtained in ninety-seven per cent of cases, even when the whole face is involved. In these eight hundred patients, with ages ranging from five to seventy-four years, the average duration of disease was eleven years. This treatment has an advantage over the X-ray in that there is no danger of burning and consequent sloughing. With the light treatment we are dealing with a known quantity, while with the X-ray we have an unknown quantity of uncertain action.

The light treatment causes no pain. A red erythematous spot and blister appears where the light is applied, and in five or six days the scab falls off and the ulcer is healed beneath, and the skin is left free from scar or cicatrix, but red. The redness, however, after a variable period fades and leaves the skin white and uncontracted, except where there has been a loss of tissue from the disease before treatment.

In conclusion, the author would state that the possibilities for the light treatment in the curing of disease are still unknown, and believes that in a limited time it will take an exalted position in the field of medicine and surgery.

*2118 W. Lake St.*

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## *Clinical Reports.*

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### CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

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STATED MEETING HELD NOVEMBER 2, 1903.

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The President, Dr. J. H. Burtenshaw, in the chair.

#### RUPTURE OF THE URETHRA.

This patient was presented by Dr. C. H. Chetwood. The boy, nine years old, fell astride the edge of a barrel. The accident was immediately followed by swelling and ecchymosis of the perineum and scrotum, which extended down the inner sides of the thighs.

On examination, the bladder could be felt slightly distended toward the brim of the pelvis. Gentle effort to introduce a soft rubber catheter was unsuccessful. The diagnosis was complete or incomplete rupture of the urethra. The patient was anæsthetized, but it was impossible to obtain entrance to the bladder through the urethra. Perineal section was then performed. The distal end of the tube was found without difficulty, but not until the perineal opening was distended with boric acid solution was it possible to distinguish and grasp the proximal end. The ends were sutured together, and a small catheter introduced through the perineal wound. Three days later the catheter was removed, and the patient urinated without trouble. Twenty-four hours later, under anæsthesia, a catheter was passed through the meatus into the bladder and tied there for three days. At the end of two weeks cure was complete.

#### PROSTATIC HYPERTROPHY AFTER GALVANO-PROSTATOTOMY.

This patient was also shown by Dr. Chetwood. The man was sixty-three years of age, a peddler by occupation. His principal complaint had been that he was compelled to urinate at least every half hour, day and night, which was accompanied and followed by considerable pain. The speaker said that urinary symptoms of this character occurring in a man of that age would naturally suggest prostatic hypertrophy, causing vesical insufficiency and cystitis. The examination of this patient bore out this hypothesis. While the prostate proved to be only moderately enlarged, the bladder contained seven ounces of residual urine, and the Thompson searcher, introduced into the bladder, recognized an obstruction at the urethral orifice in the nature of a bar. Operation was performed on February 27, 1903. Perineal section, followed by digital examination of the bladder, showed a tight vesical orifice, an elevated and hypertrophied median fold and a deep *bas fond*. This bar was incised with the galvano-cautery instrument in two places, each being three-fourths centimeter in length, forty-five seconds being allowed for each cut. A perineal tube was then introduced and left in place for five days, at which time it was removed, and in a few days the patient began to urinate through the natural channel. He was pronounced cured in three weeks. Summing up this method of operating, the speaker said that it is essentially one of drainage,

the aim being to effect, as nearly as possible, the reestablishment of the normal condition of bladder drainage, with the minimum amount of risk, the greatest dispatch, and without removing more of the prostate gland than is necessary in order to accomplish this purpose.

#### TWO CASES OF SKIN DISEASE.

Dr. Victor C. Pedersen presented two interesting cases of skin disease, one of scaling papulo-squamous syphilide, some of the lesions of which resembled psoriasis, and the other of generalized nummular psoriasis, strongly suggesting syphilis at first sight. The histories of the patients were as follows:

Case 1. Male, twenty-two years old. Eight months ago had a chancre, which left behind the typical indurated scar on the prepuce. Nearly three months afterwards a rash appeared on the skin, and the man consulted a physician, who prescribed antisyphilitic remedies, which were taken in an irregular manner for a short time, resulting in a more or less complete disappearance of the rash. About three weeks prior to his appearance at the New York Hospital, about the middle of October, the outbreak returned with greater virulence and wider dissemination. When first seen at the New York Hospital, he presented a generalized papulo-squamous scaling rash all over the body. Some of the lesions, especially near the elbows and shoulders, were so large and the scales so numerous as to strongly suggest psoriasis. Differential diagnosis was made by the presence of typical mucous patches in the mouth and typical lesions of syphilis on the palms of both hands and soles of both feet. Tonics, mercurial inunctions, and ascending doses of iodide of potash in about three weeks caused practically all of the small lesions to disappear, and only the large ones remained. The character of these larger lesions was still somewhat suggestive of psoriasis, and the case was presented for its interest and for differentiation by the members of the society between these two diseases.

Case 2. Male, twenty-four years old. About five weeks before he applied for admission to the New York Hospital Out Patient Department a generalized scaling rash appeared all over his body. In this case the lesions were frankly those of psoriasis, but resembled those of syphilis somewhat in being comparatively small and in being scattered everywhere over the body, excepting on the soles and palms. The diagnosis was made through the absence of sole

and palm lesions and of lesions in the mouth, and likewise by the distinctly psoriatic condition of the backs of the hands. Three weeks of treatment had caused the scaling to practically disappear, and the color of the underlying skin had assumed a much more healthy appearance. The treatment had been simple, consisting in simple diet and regular physical exercise and ascending doses of Fowler's solution of arsenic, with chrysarobin ointment, about ten per cent applied to small areas of the body in turn, from night to night, and ten per cent boric acid ointment applied to other parts of the skin to keep the scales as soft as possible.

Dr. F. H. Dillingham opened the discussion of Dr. Pedersen's cases. With regard to Case 1, he said he thought most of the lesions were syphilitic. On the patient's back were a large number of lesions undoubtedly syphilitic, and those on the front portion of the body resembled these, but in syphilis there is atrophy or loss of tissue. Sometimes the lesion is too small to be recognized with the naked eye; but if there is loss of tissue, it cannot be psoriasis. It leaves the skin perfectly normal, except often pigmentation disappears. The speaker made a diagnosis of syphilis and psoripheal eczema of the scalp.

Dr. E. L. Keyes, Jr., said that the case reminded him of a patient about twenty years of age who came to him with psoriasis all over his body. The case was supposed to be psoriasis, as the lesions were characteristic; and although the question of syphilis was brought up, there was no history and no evidence of a primary lesion. More psoriatic lesions appeared, characteristic ones on the palms of the hands and soles of the feet. This seemed to point to syphilis, and the patient was put on mercury, and the lesions promptly disappeared.

Dr. Pedersen said that he had brought the patient before the society for diagnosis because, three weeks before, when he first saw the man, he was put on syphilitic treatment and the improvement was marvelous. The morning of the meeting, however, the speaker and his colleague at the New York Hospital had failed to agree on the diagnosis, the speaker considering it syphilitic and his colleague claiming the patient presented a combined lesion.

#### SUBPHRENIC ABSCESS.

Dr. J. A. Bodine presented this patient, a man thirty-five years old, who had come to him with a previous history of pneumonia

six weeks before. The pneumonia had kept him in bed for thirteen days, and he had been up and about for eight days when pain and fever returned. He was referred to the speaker with a diagnosis of encysted empyema. Sweating, emaciation, and septic facies were present, and on the right lower side of the chest there was well-marked bulging. Respiratory signs were absent in this locality. To verify the diagnosis, a hypodermic syringe was inserted in the upper part of the bulging mass, between the seventh and eighth ribs, and pus was withdrawn. A section of one and one-half inches was made in the ninth rib, care being taken not to go through the diaphragm. There was no pus, but the liver and diaphragm could be felt intervening. The needle was inserted again between the seventh and eighth ribs, and pus was withdrawn. A second incision was made at this point, and when the pleura was reached six or eight ounces of clear serous fluid was found. When the finger was inserted into the second opening a dome-shaped mass was found rising over the liver. The lower border of the lung was defined and a fluctuant subdiaphragmatic abscess diagnosed. The diaphragm, was incised with a knife, and eight or ten ounces of pus withdrawn. A drainage tube was carried through the lower wound. The fever has entirely disappeared, and the patient is on the road to recovery.

Dr. Morris Manges said that to make a positive diagnosis in these cases is impossible. Absence of pneumococci might have given the clew to the origin of the subphrenic abscess. There is no part of the body in which one is more liable to err than in the lower portion of the pleural cavity in the recognition of fluid. There is nothing which fluid cannot simulate. It was Leyden who pointed this out in 1887, and gave to it the name of pyothorax subphrenicus. Since then a number of cases have been reported as secondary to pneumonia, but in such cases pneumococci are usually found in the pus from the subphrenic abscess. Another condition which makes differential diagnosis difficult is abscess of the liver, as differentiating this same condition from secondary effusion into the pleural cavity. In almost every case one finds the localized point of tenderness over the liver, and this indicates where the aspirating needle should enter. In abscess of the liver the dullness and flatness is higher in the axillary line than it is anteriorly, and respiratory conditions are present which are absent in empyema.

## UNUNITED COMPOUND FRACTURE OF THE TIBIA.

Dr. L. L. Roos presented a patient who, four weeks before, had fallen in the street. Examination revealed a compound fracture of the tibia, with two simple fractures of the fibula. The patient was sixty-seven years old, and had suffered from locomotor ataxia for eighteen years. For twelve years he was treated with silver nitrate. Four weeks after the accident there was no sign of healing in the fractures. The external wounds had become gangrenous. During his hospital experience the speaker had seen three cases of locomotor ataxia with fractures of the leg, and all three patients had been kept in bed for four, five, and six months without any union resulting, and finally amputation had to be resorted to. From lying in bed for four weeks the patient was developing paresis of the bowel, and movements were induced with great difficulty. Catheterization was necessary to draw urine at all. There was not even fibrous union in the fractures.

Dr. W. B. Pritchard said that there was no arbitrary rule for union in such cases. Sometimes it is impossible to obtain union, and in other cases the results are unexpectedly good. This kind of fracture is not peculiar to locomotor ataxia, but often occurs in connection with peripheral neuritis and with multiple neuritis, and takes on exactly the same characteristics. The bones are friable, partake of the general trophic disturbance, easily fracture, and show resistance to union. These fractures do well unless complicated. If simple, there is no external disturbance of the circulation.

The paper of the evening was read by Dr. F. H. Dillingham, was entitled

## ALOPECIA AREATA,

and was in part as follows:

"Alopecia Areata should only be used to designate a disease where the hair falls out in one or more patches, which increase in size by spreading at the periphery and leave a bald area without any apparent inflammation of the skin. In a majority of cases the disease is confined to the scalp, and after the hair stops falling out, the patch may remain stationary or new hairs, which are usually at first fine lanugo hairs, appear at the margin or in the patch. While the disease is progressing the hair at the margin is loose, with atrophied roots, and can be easily pulled out. The skin shows no signs



of inflammation, is smooth, shiny, and slightly depressed. There has been a great difference of opinion as to the etiology, some claiming it to be a trophoneurosis and others parietic. There is no question but that there are a number of cases of alopecia occurring as the result of shock or injury to a nerve, but they do not have the definite clinical history that we have in alopecia areata and should not be called such, but designated as alopecia neurotria. Simply because an area is devoid of hair, it should not be called alopecia areata.

"The manner of spreading at the periphery, the inflammatory process in the corium, the fact that the loss of hair does not follow a nerve distribution, and the number of epidemics reported seem to be conclusive evidence that the disease is parasitic and slightly contagious under favorable conditions. Although a number of different organisms have been found, none of these have been proven to be the cause of the disease.

"Salourand claims it is the same bacillus found in seborrhea, but it is also present in comedones of acne. He also claims that it occurs only after puberty, which does not explain the many cases in children. Crocker and Hutchinson believe it to be related to ringworm, but there is no proof.

"The disease which will give the most trouble in diagnosis is ringworm of the scalp, in which the patch is inflamed, the baldness is not complete, and there are the characteristics, short, broken-off hairs, with short ends. In doubtful cases the microscope will decide.

"In favus, the yellowish crusts, incomplete baldness, inflammatory symptoms, and atrophy will enable one to make a diagnosis. The prognosis is almost always good if the disease has not lasted long enough to destroy the hair follicles. If acne has been properly treated for two months, and there are no lanugo hairs, the chances are the hair follicles have been destroyed and there will be permanent alopecia. If there is any defective condition of the general health, it should be corrected; but aside from this, internal treatment is useless. Besides a large number of drugs, Rontgen rays, Finsen light, and radium have been used.

"Chrysarobin will give the best results in most of the cases, but it should not be used on the face or over too large a surface at one time. It is best used with vaseline, gr. xv. to the ounce, and it is



well not to use too strong a preparation at first. We aim to produce a mild dermititis in order to obtain the benefit of the emigration of the white blood corpuscles and destruction of the organisms. The preparation should be thoroughly rubbed in with considerable friction every night for a week, and then discontinued to see if the disease is still progressing. After the alopecia has stopped spreading, stimulating applications with massage should be used to bring an increased blood supply to the part and aid in the nutrition of the new hair."

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## *Abstracts.*

### COLLARGOLUM BY INTRAVENOUS INJECTION IN ERYSIPELAS.\*

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BY WARREN COLEMAN, M.D.,  
Professor of Clinical Medicine, Cornell University, New York.

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The favorable reports on the intravenous use of collargolum in various infections induced Dr. Coleman to try the drug. The results were sufficiently encouraging, especially in erysipelas, to warrant publication.

He used doses of five to ten centimeters of a one per cent aqueous solution. All who have used collargolum agree that it is harmless. As to technique, any sterilizable ten centimeter syringe is suitable. The veins at the elbow bend are the most convenient. The site should be sterilized and covered with gauze until the needle is inserted. A bandage tied about the arm brings out the veins. If they do not appear readily, the arm should hang over the edge of the bed for a few minutes. In no case was it necessary to cut down to the vein. A hypodermic size needle is the best, its eye being uppermost. The syringe should be held as nearly as possible in the long axis of the vein. If the vein shows tendency to roll from under the needle, slight axis traction will steady it. The disappearance of resistance before the needle generally shows that it has entered the vein. It can often be felt to "pop" into the vessel. If doubt exists, a small quantity of blood may be sucked up. All air should be removed from syringe and needle beforehand. The syringe should be inclined, so that any contained air

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\*Abstracted from the Medical Record, Nov. 21, 1903.

will rise to the piston. The fluid must be injected slowly. The vein should be covered with gauze and bandaged rather tightly immediately after the needle is withdrawn. Collargolum should not be allowed to escape into the tissue. When this precaution is taken, patients rarely complain. Very little or no reaction at the site occurs, and the same vein may be used within a day or two.

The author then details five cases of erysipelas. Three of them promptly recovered after single injections, one of them after two injections, and the last after three injections. Being convinced by an experience of some twenty cases of various diseases of its harmlessness, he recommends that the method be tried in appropriate cases. So impressed is he with the possibilities which the intravenous use of collargolum holds that he is actively continuing the work upon cases placed at his disposal by Prof. Loomis.

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### ORAL SEPSIS AS A CAUSE FOR PERNICIOUS ANAEMIA.

In an article on this subject by William Hunter, M.D., Edin. F. R. C. P., London, published in the *Lancet* (January 27, 1900), the author gives the following conclusions:

"1. Pernicious anæmia is a special form of chronic blood-poisoning—a toxæmia.

"2. It is the result of a special infection of the digestive tract, especially of the mouth and stomach, and probably, although to a less degree, of the intestines.

"3. The chief source of infection is through the mouth from long-continued and neglected cario-necrotic conditions of the teeth, and so sometimes, possibly, from stomatitis arising from other causes.

"4. The usual effect of this infection is a chronic infective catarrh of the mouth and stomach, which may in time lead to deep-seated changes—e. g., ulcers of the mouth and tongue, chronic glossitis and atrophic changes in the tongue, or chronic gastritis, with atrophy of the gastric glands.

"5. The evidence of the infectivity of the organisms of dental decay are overwhelming.

"6. The infection is chiefly streptococcal, and probably derives its special characters from being of a "mixed" character.

"7. Such infection the more readily occurs if the stomach or intestine is already, from any cause, the seat of disease.

The above conclusions suggest certain new considerations in regard to treatment, of which the chief one is the importance of minute attention to the hygiene of the mouth and especially of the teeth, with the immediate removal of every source of infection."

The importance of oral cleanliness, which is emphasized by Dr. Hunter in the above article, has lately received much attention from the medical profession. Various forms of infection, both local and general, have been traced to the mouth and teeth. In Glyco-Thymoline we have an excellent antiseptic mouth wash which not only cleanses but, on account of its alkaline reaction, prevents further decay.

It is a well-known fact that the formation of lactic acid causes decay of the teeth, and that this process is absent or at least proceeds very slowly when the saliva is alkaline. Normal human saliva is slightly alkaline, but the alkalinity is so weak that few mouths are capable of a prompt recovery from the acid condition, nor is the alkalinity usually strong enough to counteract the acids of decay; hence it seems rational to endeavor to supply this deficiency.

Saliva is composed in part of mucus, which is readily soluble in a properly combined alkaline solution, while it is insoluble in alcohol, ether, or acid solutions. Bacteria develop rapidly in this undissolved and undisturbed mucus in and about the teeth, causing continued and increased acidity of the saliva.

These facts indicate that an alkaline solution is needed at the portal of the body for protection.

Dr. A. H. Peck's analysis of a number of mouth preparations proved that but one of the many had the essential feature for the purpose desired—namely, that of alkalinity. This solution was Glyco-Thymoline.

Alkaline saliva seems an undoubted aid to digestion; and if it can be induced to flow and be kept alkaline, many stomach disorders will disappear.

The mucuous membrane, under the action of Glyco-Thymoline, becomes hardened and normal, and naturally offers greater resistance to disease. The daily application of the remedy as a mouth wash does much good, maintaining an alkaline or normal condition.

Glyco-Thymoline is a scientifically prepared solution, of the alkalinity of blood serum, and of correct specific gravity, forming an agreeable, nontoxic, alkaline alterative. It readily dissolves the mucus which forms part of the salivary secretion, and thus penetrates every cavity of the teeth and mouth. It has a distinctly alterative effect upon mucous membrane, acting by exosmosis, thus not only reducing inflammatory engorgements and establishing a normal condition, but also maintaining this condition by continued use.

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### UROTROPIN IN THE PROPHYLAXIS OF SCARLATINAL NEPHRITIS.\*

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BY DR. J. WIDOWITZ, GRAZ, AUSTRIA.

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The beneficial action of Urotropin in vesical catarrh, pyelitis, and phosphaturia recorded by so many authors and ascribed to the disinfectant action of the formalin separated from it in the urinary passages, induced me to use Urotropin in scarlatina to prevent the advent of nephritis. For it is probably correctly assumed that the latter is due to the as yet undetermined scarlatinal microbe or its toxines, and an efficient antibacterial agent applied to the site of the infection may inhibit the pathological changes that mark the renal affection.

During the past three years I used it in one hundred and two cases. From three-quarters to seven and a half grains were given thrice daily for three consecutive days at the onset of the disease, and the same doses were given at the beginning of the third week, when nephritis most commonly occurs. Children from one to fifteen and an adult of twenty-one were treated in this way. The remedy was always well borne. I have not seen nephritis occur in a single case, although it is the most common complication of scarlatina. Johannessen has seen it in as few as sixteen per cent and as many as ninety per cent of the patients. It occurs especially in mild cases, which were the most frequent.

Two cases deserve especial mention. A girl of eleven sickened with a fairly mild attack. On the fifteenth day large quantities of albumin were present in the urine. Five grains Urotropin t. i. d.

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\*Abstracted from the Wiener Klinische Wochenschrift, Oct. 1, 1903.

Two days later the albumin permanently disappeared. Another girl of eleven had had paroxysmal hemoglobinuria for eight years. When she fell sick with scarlatina, hemoglobinuria at once appeared. Urotropin five grains t. i. d. Urine free from blood coloring matter on the third day. On the fourteenth day, temperature rose to 100.6 degrees and hemoglobinuria reappeared. On the eighteenth day Urotropin was again given, blood coloring matter disappearing four days later. The absence of nephritis in my one hundred and two cases may possibly have been accidental, but it certainly urges to further clinical trials.

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## *Records, Recollections and Reminiscences.*

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### THE WINDER HOSPITAL, OF RICHMOND, VA.\*

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BY ALEX. G. LANE, M.D.,  
Late Surgeon C. S. A., of White Oaks, New Mexico.

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Standing in the hall of my *Alma Mater*, where in the prime and innocence of my youth, forty-five years ago, I was commissioned to care for the lives of fellow-beings, I would not, in the happiness of this moment, rend from my life's history any of its darkened leaves; for in the bright eyes and intellectual faces around me I see written upon memory's tablet, in golden characters, your confidence and esteem. No! Welcome the past, since it is the background of patriotic adherence to principles enunciated to us by Jefferson, Washington, Henry, Campbell, Shelby, Morgan, Rutledge, and a host of others, who combined eminently all the nobler qualities of heroes and statesmen and left to the world names synonymous with virtue and luminous with public integrity. No! Welcome the present, since the love-crown of consciousness of duty done has drawn us together, pointing each other to altars of courage and constancy to our own Southland homes of beautiful women, sunshine, and flowers, with only one glory, to prove ourselves faithful to friends and formidable to foes. Whatever humble or

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\*Read at meeting of Association of Medical Officers of the Army and Navy of the Confederacy. at New Orleans, La.

important part either of us may have performed in this greatest drama, "Liberty Enlightening the World," we meet to-day wiser men, knowing the achievements of that "mighty conflict of brothers" which has accomplished the solidity of States, the perpetuation of the Union, and its present distinguished position before the world—arbiter of nations and empires. We meet to-day as at camp fires of yore to recite to each other our little part fought, won, or lost.

Having received degrees of Bachelor and Master of Arts at Centenary College, Jackson, La., in 1854 and 1856, twelve months resident student of Charity Hospital, graduate of Tulane University, class of 1858, a successful cotton planter in Carroll Parish, La., I submitted the question of slavery to the arbitrament of the sword, believing that it was in the defense of its plain relations to the constitution of the United States, entered service in my native State, with the Mississippi College Rifles, elected to deliver the valedictory to citizens of Clinton, Miss., in the vigor of youth, burning with inspiration of patriotism, I fired a thousand assembled citizens to shouts as I walked off the platform, carpeted with showers of bouquets from hands of Mississippi's fairest daughters. I allude to this occasion not in any self-praise but to recall to your memory how the fires of secession were then burning, and how the hearts of our boys were inspired by fathers, mothers, and daughters of the Confederacy to perform well their part. After six weeks in camp of instruction at Corinth, Miss., we were ordered to Virginia with Col. Burt's Eighteenth Mississippi Regiment, fought the first battle of Manassas; received commission as surgeon P. A. C. S. dated June 6, 1861, as I came off the battlefield of Ball's Bluff, and made staff surgeon by commanding Gen. Evans.

The Federal sick and wounded received from the battle of Ball's Bluff (one of the most decisive and fruitful battles of the war, with only thirteen hundred Confederate muskets engaged, but which eventuated in the killing of two thousand one hundred men, capture of eight hundred stands of arms and three mountain howitzers, sending seven hundred and fifty prisoners to Richmond, and turning back a column ten thousand strong commanded by Gen. Stone, who was afterwards cashiered, and where Gen. Baker, of Oregon, was killed) who were not able to be forwarded to prison quarters at

Richmond were placed in a hospital organized by me and in my charge at Leesburg, Va., and received the same bedding, rations, and medical attentions as Confederate soldiers.

A very interesting case (a man of the Seventeenth Massachusetts Regiment, a native of the mountains of Vermont, a perfect athlete, over six feet high, one hundred and eighty pounds in weight, and never sick a day in his life) was admitted with his arm torn to fragments by grapeshot. I amputated the arm just above the seat of injury, in the upper third of the humerus (using this scalpel for a surgeon's knife and a carpenter's tennon saw to cut the bone), and it healed by first intention and he was discharged in fourteen days after receipt of the wound, sound and well. The ligature was removed on the ninth day with but a drop of suppuration at each suture, and in three days the cicatrix was complete.

The Winder Hospital and grounds—covering one hundred and twenty-five acres of land, with a capacity of four thousand eight hundred patients—was organized in April, 1862, and conducted by me for three years, or until within ten days of Gen. Lee's surrender. It consisted of six divisions, each in charge of a division surgeon and six assistants, with its appropriate dispensary, laundry, kitchens, and corps of matrons, nurses, and attendants, the whole surrounded by a guard of one hundred and twenty-five men under a commissioned captain. Attached to the hospital was the most approved Russian, steam, plunge, and shower baths, a bakery with a capacity to bake for ten thousand men daily, sixteen acres of hospital garden (worked by convalescents), a dairy with sixty-nine milch cows, with appropriate barns and stables, the dairy yielding three hundred gallons of milk daily, an ice house forty feet square and twenty feet deep filled with ice, a commissioned captain of commissary with commissariat, and a medical examining board of three surgeons, giving me a command, at twenty-seven years of age, with eight hundred hospital attendants, ranging from two to five thousand men.

I had a six-foot ditch cut down a hollow from the central grounds of the hospital leading toward the James River, over which was constructed a line of water closets and two ten-thousand-gallon water tanks, which were pumped full of water and the ditch flooded every other day, carrying off all débris and filth from the hospital grounds. By permission from the Secretary of War, I had con-



structed two canal boats that run up the Kanawha canal and furnished the hospital from the mountains with weekly supplies of fresh butter, eggs, chickens, geese, turkeys, honey, and every other necessity that the vast hospital fund amounting to twelve hundred and twenty thousand dollars, created by commutation of army rations and from the hospital bakery, could obtain for the sick and wounded, who were often regaled in their hot fevers during the summer months with ice cream, custards, and lemonades. On sundry occasions the Federal sick and wounded were sent to this hospital, where they received the same rations, medical attentions, and privileges as other patients. Frequently for weeks the bread for prisoners on Belle Island and Libby Prison was baked at the hospital bakery, and was the same in kind as that used in the hospital. All wines and liquors—the best grades of which were obtained through the personal friendship of Mrs. Snowden (blessed be her memory!), President of the Ladies' Hospital Association, of Charleston, S. C., via blockade runners from Nassau—were dispensed through hospital matrons. No medical officer was allowed to touch it under penalty of immediate orders to the field.

The government of Winder Hospital was the inspiration of every official and attendant, with a laudable ambition to excel. To this end I told every medical officer reporting to me for duty, that printed rules and regulations of the hospital were posted in every apartment; that I was its head, fired with love and zeal for duty; and that every official and attendant in it was there with a high purpose and a firm resolve to make for it a record—one harmonious whole in loving-kindness to its sick and suffering.

“Will you be one, with its chief surgeon, to add joy to your environments and say when you lie down at night, ‘I have lived this day to relieve the suffering of those around me?’ We are all here, in this mighty conflict thundering at the very doors of our capital, for a record of every duty accomplished. I well know that it is a custom with many medical officers in the field, when they draw their monthly supplies of liquor, to call in their regimental officers and drink it up. I well know that many officials when they get into new suits of clothes, a star or bar on their collars, begin to feel that they are better and look down on the rugged soldiers around them, but this is not truth. Many patients in this hospital are socially, intellectually, and financially our peers. You will be required to



treat them and every attendant with the same courtesy and decorum that marks you to be a Southern gentleman. Believing that we always get the best there is out of our fellow-beings—that is, of their mind and heart, I make this appeal to you to emulate the example of your chief surgeon in the fulfillment of every personal and official duty; and now I challenge you—every person in this hospital—to see that I toe the mark of its regulations, and rest as the best service—by appealing to the nobler and better attributes sure that I shall see that every official performs well his part.” At trumpet call every day, except Sunday, the six division surgeons met me at my office to inspect one of their divisions. This I did promiscuously, so that they were all compelled to keep their divisions in perfect order, not knowing their day for inspection. If I found everything in commendable condition after inspection, my rule was to dismiss them with some complimentary remark to the surgeon in charge. From this sprang a laudable ambition in each division surgeon’s heart to have as much said for them upon their day of inspection. This rule worked so successfully that after a few months I confessed to them that it was my secret of government of Winder Hospital, and I then reminded them that the lives of all the great rulers and governors in the world teach us that man, to make a success in all he attempts, must *first* become interested in the work, *second*, learn to *control himself* before he is fitted to control others, and *third*, give it inspiration *by personal example*. I then exhorted them, in glowing language flowing from my own heart, not only to adopt this rule in their respective divisions, but each to labor to excel the other in inditing it in the daily life and labor of every subordinate official and attendant in their divisions of the hospital. They responded promptly and pledged the best there was in them to my support. This *proved the key to success*.

I next organized a quiz class, consisting of six division surgeons and myself a faculty, each in charge of a chair in surgery, chemistry, therapeutics, anatomy, etc. We met weekly, having lessons assigned for the previous week’s study, when the professor for each evening would question the class; then at the close of the lesson, close his book, and have us come back at him, every member with a question on the lesson. The result of this work was that we were all refreshed in both theory and daily practice, drawn to-

gether both socially and intellectually. Every member passed with flying colors before the Army Medical Examining Board, and thirty-three assistant surgeons in Winder Hospital were promoted to full surgeons.

It may interest you to know that Miss Emily Mason, niece of Senator Mason, of Mason and Slidell Ambassador notoriety, was chief matron of the first division of Winder Hospital, and that her personal friends, two daughters of Robert E. Lee, Mrs. Secretary Randolph, Mrs. Grant, wife of the richest tobacconist in Richmond, with many others, would frequently drive out from Richmond in their fine carriages to visit the sick and wounded, became interested in the family history of some wounded soldiers, sat down by their bedsides, and wrote letters to their loved ones at home, and even fed them like mothers with delicacies and viands they would bring out daily from their own tables.

I hold before you chief surgeons the official record of Winder Hospital Fund Book, which I now commit to the archives of army and navy surgeons, in which will be found the cardinal facts that I disbursed twelve hundred and twenty thousand dollars of public funds from April 1, 1862, to March 1, 1865, that seventy-six thousand, two hundred and thirteen sick and wounded were admitted, eleven thousand, five hundred and thirty were transferred to other hospitals, leaving sixty-four thousand, six hundred and eighty-three to be treated in Winder, with three thousand, two hundred and fifty-nine deaths, just five and two-tenths per cent of mortality—a record at that day unprecedented in the annals of general military hospitals, whether in the North or Europe.

I hold before you this clipping from the Richmond *Enquirer* of the proceedings of the Confederate States Senate, in which you will find that as early as September 25, 1862, the mortality in General Hospital No. 2 was ten per cent; in No. 13, fourteen per cent; in No. 9, twelve per cent; in No. 5, thirteen per cent; in No. 23, twelve per cent; and in the balance each eight, nine, and ten per cent, except Winder, a remarkable exception, where, out of twenty-two thousand, eight hundred and seventy-four patients treated, the mortality was only six per cent.

In conclusion, permit me to remind you, comrades, that every person, State, or nation that stands for the defense of the right and the truth must have a history of conflicts and sorrows; that the

memorial which binds you to the great heroism and mighty sacrifices of the past has already become a bow of promise to American grandeur and power through the gallantry of your sons during the Spanish-American war, forming a mighty prism to reflect the noontide radiance of your achievement into a halo of glory to encircle the brow of your departing worth; that to-day this giant young republic is thundering past the old nations and decaying monarchies of the East with the rush of the limited express; that her public school system is not only the boast and pride of her citizens, but the palladium to her progress and power; and that, having produced seventy billions of wealth in a little over one hundred years, she is to-day, in population, annual saving, public credit, agriculture, mining, manufactures, consolidation of personal capital (as factors to commercialism), education, and munificent endowment of universities, a blazing meteor before the civilized world, forty per cent richer in material wealth than any nation on the earth; and that the Anglo-Saxon race now belts the world. It has laid the foundation of our Western republic and started it off on a career of monumental commercialism, progress, and prosperity. Under its beneficence to the human race, universal education, and a free ballot, its grip upon the masses will not be relaxed as the battle for unity, right, and justice to its humblest and poorest citizen waxes hotter, but will rather tighten its hold and increase its power (see late merger decision) over trusts and commercialism, until language, custom, and purpose are one, until, under the banner of control of the holy trinity of liberty, religion, and universal higher education, America will give law to the world and Anglo-Saxon supremacy will mold its multiform elements into complete accord with this union, and the Christian religion shall direct the whole for humanity and God.

Are you not all proud, gentlemen, to know that you are living factors in this grandest achievement of the nineteenth century for the elevation, advancement, and happiness of man?

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GUDE'S PEPTO-MANGAN THE STANDARD.—Iron preparations spring up like mushrooms in a night. The one backed by clinical evidences in hospital practice is the old stand-by, Gude's Pepto-Mangan, which is the standard of known worth and which gives positive results.—*Medical News, New York.*

## *Editorial.*

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### BEGINNING ANOTHER VOLUME.

Quite a number of our subscribers (some who have been with us continuously for years, others for a shorter time) have gratified us no little, not only with their renewals of subscription in advance, but more by the kindly and complimentary expressions in regard to our editorial work. It demands not only the personal acknowledgments made, but also a continued effort on our part to see that the new year shall bring them no disappointment so far as concerns the reading matter to be found in *THE SOUTHERN PRACTITIONER* during the coming months. The encouragement will justify our most earnest and sincere efforts along all lines of medical and surgical progress. A single letter from a recent graduate in medicine, his subscription beginning just one year ago, suggests that the matter contained in our "Records, Recollections, and Reminiscences" might be filled with other matter. To this we will say that when this department was added to the journal sixteen pages more reading matter were added to its former number of pages. So this is, as it were, "a chromo" thrown in, which can be read or left unread. It has, and will contain, matter covering a period in which the literature of our medical friends in the South is quite limited. It has received commendation after commendation from surgeons who wore the "blue" as well as those who wore the "gray." It has placed on the printed page valuable facts and incidents that would perhaps never have seen the light, that every doctor, especially in the South, may well feel a pride in. The work that was done in field and hospital by the Confederate States medical staff was too valuable to be left unrecorded. Much of it can never be rescued from oblivion, but our efforts in rescuing so much of it as we possibly can, we feel confident, will be appreciated not only now but in the years to come. Yes, we propose to continue this as well as put forth our best efforts along all lines of progress and advance.

The following letter from Dr. James M. Holloway, of Louisville, Ky., we beg leave to place before our readers:

"Your December issue notes the death of three of my Confederate friends—Chisholm, Gaston, and Mitchell. Gaston and I were together on the field, and Bob Mitchell and I were everywhere together and like brothers.

"I am only a year or two younger than the youngest of the three, and, while still in active practice and teaching, am looking forward to some incident of exposure that will put me to bed, and thus finish me. It rejoices me to see such favorable notices of these three good men in your journal—men who were so modest that they would shrink from any ante-

mortem eulogy that was strickly personal. I thank you kindly for the information this number of the journal contains, and am pleased to discover other material that will be valuable to your list of subscribers."

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### MEDICAL SOCIETIES.

In the numbers of this journal of last year medical organization has occupied quite a prominent place. The time was opportune for active work, and if we have added a little even to the great work that has recently been accomplished from one end of the land to the other, we can feel that our efforts have not been in vain. Having always had an abiding confidence in the great good that would result to all—both the profession and its clientele—in a thorough organization, we have endeavored to do our part in its behalf. However, we do not propose to stop yet, and sincerely hope that the coming spring months will add as many to the membership of the county medical societies throughout the entire country, and especially in our own State, as was done in the past year.

Take a careful look at the membership of the American Medical Association during its entire existence for many years of any State, or local organization, and you will find enrolled therein the ablest, the most successful, the most prominent medical men of the particular time under consideration. Our busiest members have found time to participate in the meetings, if not every year, at least a great proportion of the time. Occasionally we have made overtures to professional men in regard to participating in society work, and have been met with the statement, "We are too busy," "Could not spare the time;" yet a careful observation has forced the conclusion that such would have done better if they had never opened a medical book, and had devoted their time and talents to some other vocation. Unquestionably times do occur that professional or other duties will prevent attendance on a given meeting of a local or State society, and all cannot attend the annual meetings of the National Association; yet, if each member of the profession will but endeavor to participate in as many meetings of his local society, and occasionally attend a meeting of his State organization, he will find that the time so spent will be of more intrinsic value in the end than double the time spent in any other duty—yes, we regard this as a duty incumbent on any practitioner acting for the best interests of himself and those dependent on him for professional services. This may be regarded as a strong statement, yet it is the result of careful observation during more than forty years of professional life, and we know will be substantiated by the leading medical men of this and all other enlightened and civilized countries.

Much has been said about the benefits and advantages of organization. Its results are seen everywhere, and to no body of men is it so important, so necessary and essential, as it is to the members of the medical profession. Except in occasional instances of consultation, their very work

leads them to segregation and isolation. A daily duty of making visits as a duty renders to some extent social visiting irksome; and even though one is an omnivorous reader of standard and periodical literature, he is apt to get into a groove, be limited in his views and resources, narrow in his observation—all of which is overcome by an occasional meeting with a collective number of others, some his inferiors, others his peers, and possibly a few his superiors in like work. By such association he adds his experience to that of others, and has the far wider experience of others added to his. Not all at one time, but a little at this meeting, more at another, and when he has established the habit—we are all more or less creatures of habit, of becoming a regular attendant at even local society meetings—it is astonishing how his entire methods, measures, manners, and life in all its technical details are broadened, advanced, and materially increased.

By organization and regular meetings personal jealousies, petty bickerings, slanderous and scurrilous backbitings disappear and are supplanted by a broad and liberal ambition and emulation as to who can excel and who can add the more to the sum of professional knowledge, skill, and correct technique. Nor is it alone from the papers, essays, and discourses thereon that we can and do derive a national benefit. Some of the most practical and valuable ideas and suggestions ever received have been obtained in the personal conversation with other medical men in attendance on a meeting. While many valuable ideas and thoughts have resulted from careful attention to the regular programme, yet some of far more value have been obtained in the social intercourse and conversation on assembling before the meeting was called to order and after its close.

However, as we have been, to some extent, running a "serial" along this line for some months past, we will bring this the first section of 1904 to a close with the following extract from a communication by Dr. George J. Monroe, of Louisville, Ky., in the *Cincinnati Lancet and Clinic* of December 12, 1903, which is quite "meaty," and contains some very pertinent suggestions. In giving his views of the last meeting of the Ohio Valley Medical Association to our valued contemporary, he has the following:

"I was invited by Dr. A. M. Hayden, Chairman of the Committee of Arrangements, to attend the annual session of the Ohio Valley Medical Association, which met at Evansville, Ind., November 12 and 13, 1903. He requested me to prepare a paper on some medical subject and to read it at

the invitation and prepared a paper for the occasion. I no number of doctors received the same invitation and agreed to read papers at the meeting. Such names and papers appeared in the programme, and yet many of those who made this promise did not appear at all. There were six or seven Louisville doctors named to be present and to read papers who did not attend, and in the daily papers that some of them had been present, had

read papers, and these papers had been ably discussed. Now, I believe that a physician should fulfill a promise of this nature. The programme is arranged for certain papers and discussions; and if these papers are not read, it is a disappointment to those in attendance, for they go with the expectation of hearing these papers read and discussed. It is also a disappointment to the committee of arrangements, who have been depending upon these promised papers. Furthermore, I think we may say, very often it is simply lying on the part of these physicians. Of course circumstances may arise which would make it impossible for some physicians to attend, but we would hardly suppose that these conditions would take place at one and the same time with a dozen. I think there were nearly that number absent who had agreed to be present and read papers.

"Fortunately, there were a number of volunteer papers and discussions which profitably filled up the time. Physicians promising papers and having their names appear on the programmes, and then not complying with their promise, looks to me to be a cheap way of advertising; hardly an honest way, I think. Having promised to read a paper at this convention, I considered myself in duty bound to do so.

"I will here say a word about papers and the preparation of papers for medical associations. I took for the subject of my paper 'The Rectal Specialist, or the Birth and Evolution of the Rectal Specialist'—a very broad field to condense into a twenty-minute paper. I am not gifted with a large vocabulary of words, yet upon reading the first paper I prepared upon the subject I found that it took me fifty-four minutes to read it. I had not then said all I wanted to. I knew this would never do, so I began to eliminate and condense. I rewrote the paper, cutting out all it seemed to me that I could. I found that it took thirty-two minutes to read this paper. Again I rewrote the paper, and upon reading it this time I found that it only required nineteen minutes. I compared this paper with the first and second, and I was surprised to find that I had really said more than I had in either of them. When I say I had said more, I mean more facts and matter actually pertaining to the subject. Now, then, I think this will apply to the majority of papers read before medical associations. The greater number of them could be materially condensed and yet contain all that is expressed in the long papers. How many papers we find that are filled with useless matter, matter that has no relation to the subject which the paper is supposed to treat—matter, in fact, that the general practitioner cares nothing about—matter that instructs no one! How many writers shoot all around the bull's-eye and hardly ever strike the pupil! What cares the busy doctor about a lot of statistics and data relating to the prostate, pancreas, spleen, thyroid gland, etc.? No, what we want is to learn the best way to diagnose and treat these diseased conditions, not caring a pin for the number of cases treated by this one and that one. As far as I am individually concerned, when I run across one of these long-winded, long-worded papers in a medical journal, full of names and dates and statistics, I pass it by and read some paper which tells me what to do. These long-drawn-out,



polished, big-worded articles upon medicine or surgery have no attraction for me. I must admit, however unusual it may be, and however erroneous it may appear, that many of these long, so-called original papers I pass over, and simply read the discussions upon them. The discussions generally contain the meat of the nut. They cover the ground in a condensed and concise manner. We can in this way obtain a knowledge of the papers read by reading a few words in place of reading a great many.

"Discussions of papers are usually limited to five minutes. A great deal can be said in five minutes, provided the one speaking confines himself closely to the subject-matter. But when he speaks one-half of the time in complimenting the speaker, then some time in excuses, he cannot say very much in the two minutes remaining. I think it would be well if the complimentary part was understood, and that no excuse or apologies were made, but let the five minutes be used in actual discussion of the papers.

"About the only criticism I have to make is that our good-natured President did not limit the essayists to twenty minutes and those discussing the papers to five minutes. The trouble, I believe, with many doctors is that they have an idea they will be classed with great men on account of their many words. I think this is a great mistake, for I believe doctors desire always to reach their point of destination by the most direct route they can take, and I believe papers ought to be prepared with that object in view. I know that in my own case in writing I use more words than are necessary. The trouble often is with myself, and no doubt with other doctors, that we have not the time to use few words. The use of few words to express ourselves is generally more difficult and requires far more study than the use of many. It requires far more time to prepare ourselves to say little and mean much than it does to say much and mean little. It may be excusable sometimes to say meaningless things to our patients, although this I do not indorse, but we should not attempt to do so before a learned convention of doctors."

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#### TREATMENT OF SEPTIC CONDITIONS.

Writing on the action of Unguentum Credé (Therap. Monatshefte, October, 1903), Dr. Rommel, of Neuzelle, reports that in a long series of cases his results were satisfactory beyond all expectation. He inuncted the ointment for from fifteen to twenty-five minutes with large, linen-covered corks with rounded edges, the dose for adults and older children being forty-five grains, for small children thirty grains, and for infants under twelve months fifteen grains. The integument was immediately covered with rubber tissue.

The author's results in septic processes entirely agree with those of Dworetzky and others; the ointment has usually a most wonderful effect on acute septic phlegmon, chronic osteomyelitis, erysipelas, puerperal fever, mastitis, and chronic furunculosis. Rommel appends some characteristic



case histories. In articular rheumatism his results also confirm those of other investigators. Cure was at least as rapid as under the salicylate treatment, and large joint effusions disappeared in a surprisingly short time. There is reason to hope that cardiac complications will be less frequent under the silver treatment. Patients who had previous attacks rejoiced that they did not again have to take salicylic acid.

Excellent results were attained in appendicitis when the salve was used before pus formation. Under inunctions of forty-five grains twice daily the fever ceased by the fourth day and the tumor retrogressed unusually rapidly. Similar happy effects were seen in pneumonia. The patients were afebrile on the fourth day after the chill, and simultaneously the pain, bronchial breathing, and dullness quickly diminished. The salve has a marked resorbent effect, especially evident in the pleurisies; in an average time of fourteen days the exudates, many of which were very extensive, partially or entirely disappeared. This encouraged Rommel to try the ointment in old cases with extensive adhesions of the costal and pulmonary pleuræ, so that puncture removed only small quantities of serum, and fever and exudation recurred every few days or weeks. The author believes that absorption was exceptionally rapid; the fever ceased quickly and permanently.

The action of the ointment in influenza was noteworthy. In the usual epidemic there was a whole series of cases in which salipyrin proved useless; complications were expected, but were prevented by Unguentum Credé both this year and last. He always gave two or more further inunctions to prevent recrudescence.

The author found the ointment very useful in tonsillitis and threatened abscess of the glands. A single inunction often caused marked subjective improvement, and two or three further treatments before pus formation cut short beginning tonsillar abscesses.

Rommel had abundant opportunity to observe the action of Unguentum Credé in two large epidemics of scarlatina and measles. The children were treated only with inunction, and the results were surprising. Usually by the fourth, and more rarely only by the fifth, day defebrilization occurred. In cases of scarlatina in which there was a diphtheritic exudate, antitoxin was employed besides the inunctions; and in these cases the children got up on the fourth, or latest the sixth, day. None of the measles cases developed otitis media, not even children who formerly had middle ear disease, while this was frequent with cases not treated with the ointment. When earache and reddening of the drum had already begun, all these symptoms disappeared; even cases in which the manifest exudation behind the drum rendered the prospect of paracentesis apparently inevitable escaped the operation. Larger doses twice daily removed pain, fever, and local inflammatory symptoms, and the patients recovered without further treatment. All children complaining of earache in connection with a cold or an attack of influenza should have the inunctions even before there are any objective specular symptoms.

The doses mentioned in the beginning are the smallest from which results can be expected. In severe cases he gives larger and more frequent doses. Thus in pneumonia and puerperal fever he used 1 to 1¼ drams twice daily. Cases in which time has been lost and in which an energetic action is indicated should have Collargolum intravenously.

In the treatment of the fever of consumptives, however, the ointment proved ineffectual.

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**BIOPASM** is Nature's own tonic and sustainer of the adrenal system. It is something absolutely new in therapeutics. It appeals (see formula inclosed) so directly to the basic cell functions of the system that its therapeutic action is remarkably prompt, and resultant vital incitation is positive and permanent. Bioplasm restores normal tone and power to the sympathetic nervous system by the strictly physiological process of restoring functional capacity.

Bioplasm positively and promptly corrects malassimilation and faulty metabolism, and thereby restores to every form of the cell life of the system the capacity to receive maximum nutrition; hence it is indicated in all conditions involving malnutrition.

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**PASSIFLORA.**—In the functional wrongs of women Daniel's Bonc. Tr. Passiflora Incarnata exerts a remarkable curative influence. It is indicated for all disorders of the female system, such as dysmenorrhea, leucorrhea, and menorrhagia. In acute congestive headache, chronic insomnia, neurasthenia, and nervousness produced from any cause Passiflora acts readily, giving instant relief and inducing healthful sleep, from which the patient awakes refreshed and in possession of his normal faculties. It is unequalled as a sedative, hypnotic, and antispasmodic.

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**TYREE'S ANTISEPTIC POWDER.**—"Invalidism in Girls and Young Women" was recently discussed in a most interesting and instructive way by Dr. W. E. Anthony, of Providence, R. I., ex-President of the Providence Medical Society. Dr. Anthony laid especial stress on guarding girls from overstudy during the first climacteric, recommending that they should not be kept in school more than three or four hours up to the age of seventeen, and suggested that not only were their nervous systems bankrupted by too great burdening during school life, but that their reproductive organs were not permitted to properly develop, and serious diseases and permanent injury of the uterus and ovaries frequently resulted. Dr. Anthony emphasized the fact that these run-down states were often accompanied by vaginal catarrhs most distressing. He recommended for such cases general internal tonics, blood and nerve builders, and the local use of douches daily of a teaspoonful of Tyree's Antiseptic Powder to a pint of warm water, and this treatment has been indorsed by leading practitioners for many years.

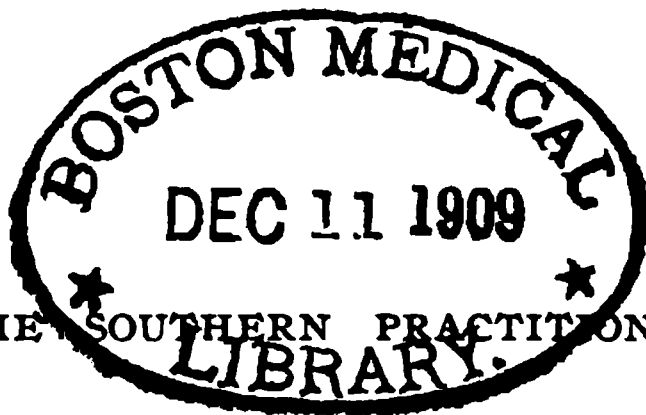
**TRUE FOOD VALUES.**—Under this head the September number of the *Dietetic and Hygienic Gazette* raises a signal that should attract the attention of every physician. It says, among other things: "It is by no means an uncommon thing to find a patient endeavoring, under the advice of his physician, to subsist on some liquid food preparation without the ingestion of a sufficient amount of real food to support the needs of the system." The same article refers to Dr. Harrington's report in the *Boston Medical and Surgical Journal* of March 12, in which he says "that most of the liquid food preparations on the market contain a far larger quantity of alcohol than nutritive material; that the quantity of alcohol by volume ranges from 14 per cent to 23 per cent, as compared with from 6 per cent to 19 per cent in solids; and, therefore, the administration of full doses of those preparations results in the free use of alcohol and in the administration of small quantities of actual nourishment." A good, sound beef diet, then, would appear to offer a maximum of food value, and while there are good grounds for objections to raw meat, a partially digested product should, in our opinion, offer the most desirable form in which beef may be employed. And this is confirmed by experiments that have recently been made by the medical laboratory of the United States army in Washington, under the direction of former Surgeon General Sternberg. This work was carried on for some months, and most exhaustive and careful experiments were made, with the result that Soluble Beef was placed upon the "supply table" of the United States army as representing the maximum of food value in a convenient and concentrated form. The value of Soluble Beef as a food product is generally recognized, and the fact that with it a more nourishing broth may be made than it is possible to make with fresh meat by the usual household methods should recommend it to the busy practitioner and the hospital where the meat press is still used. As Soluble Beef is in a paste form and stable, and may be handled without special knowledge or instructions, it commends itself particularly where the family have to be depended upon to feed the patient. It is a product that is certainly worth careful consideration on the part of every practitioner.

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## RESOLUTIONS ADOPTED BY THE SOUTHERN MEDICAL COLLEGE ASSOCIATION.

At the last meeting of the Southern Medical College Association, held in Atlanta, Ga., December 14, ult., the following resolutions were adopted:

*Resolved:* 1. That no ticket or credentials shall be issued by a school belonging to this Association proposing to give credit for a course of medical lectures to a student who has not been in actual attendance and answering roll call for at least 80 per cent of a six months' course, and that no



ticket or credentials shall be accepted as a credit or in advancement which does not show upon its face this evidence of 80 per cent attendance upon each and all courses sought to receive credit for.

2. That in every instance where a student graduates from a school belonging to his Association he or she must have been in actual attendance upon the course immediately preceding the said graduation 80 per cent of six months—except in instances where students have been forced, from sickness or other unavoidable causes, to drop out during their graduating course, in which event the course may be completed in the same school in a subsequent year by attending sufficient time to make up the time lost in the preceding course; or a student failing to graduate in one or more branches may attend a partial subsequent course in the same school, sufficient to pass off such branches. But the degree or diploma can only be awarded at the commencement succeeding such making up of deficient time or branches.

3. That one course of lectures in pharmacy, where the student has simply matriculated and attended in pharmacy and has not matriculated as a medical student, paid fees as a medical student, and pursued all of the studies as a first-year medical student, shall not be entitled to any advancement or credit in medicine by reason of this pharmacy work, and such a student must enter the medical department as though he had had no preliminary study.

4. That where violations of the laws of this Association are reported to the Judicial Committee of the Association it shall be the duty of the said committee to carefully inquire into the facts connected with such charges, after giving the accused college ample opportunity for explanation; and, if found to exist, to report the same with facts and evidence to the Secretary of this Association, who, with the President and Vice President, shall constitute a committee whose duty it shall be to communicate the findings of the Judicial Committee to the State Boards of all Southern States, giving the name of the college and the name and address of the student or students in whose behalf the infractions of law were perpetrated; and these actions shall be taken at once, and before students have been admitted to professional rights in these States.

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THE BEST for fortifying the systems of those susceptible to diseases, such as Colds, Grippe, and Pneumonia, so prevalent during the winter months, is Extract of Red Bone Marrow, a palatable and highly nutritious combination of marrow cells, nuclein, hemoglobin, and c. p. glycerin. The Tuberculous should take this preparation regularly because it is a great flesh and blood maker and quickly repairs wasted tissue.

The Extract of Red Bone Marrow is assimilated readily and aids rather than taxes the digestive organs.

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For shaking palsy nothing excels tinct. Aesculus Glabra, one-half drachm; Celerina, eight ounces. Teaspoonful every two or three hours.

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION at its last meeting, held in Atlanta, Ga., December 15-17, elected the following officers for the ensuing year:

President, Floyd W. McRae, Atlanta; First Vice President, George S. Brown, Birmingham, Ala.; Second Vice President, J. Spelton Horsely, Richmond, Va.; Treasurer, Charles M. Rosser, Dallas, Tex.; Secretary, W. D. Haggard, Nashville, Tenn.

Dr. Richard Douglas, of Nashville, and J. Wesley Bovee, of Washington, were named to fill vacancies on the Board of Council.

Birmingham, Ala., was chosen as the place of holding the convention next December.

Two thousand dollars was appropriated for a monument to the late Dr. W. E. B. Davis, one of the founders of the Association and for a number of years its Secretary. The monument will be erected at Birmingham, and will be unveiled at the next meeting.

The last meeting, as were all of its predecessors, was characterized by an unusual amount of most excellent work.

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NEW ORLEANS POLYCLINIC.—Seventeenth Annual Session opens November 2, 1903, and closes May 28, 1904.

Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialists are fully taught, including laboratory work.

For further information address the New Orleans Polyclinic, Post Office Box 797, New Orleans, La.

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RHEUMATIC PAIN AND FEVER.—In the *Medical and Surgical Bulletin* we find the following under the caption of "Acute Articular Rheumatism," by Dr. E. G. Evans: "Salol is the best intestinal antiseptic we have, and Antikamnia as a pain reliever is, without doubt, unsurpassed; therefore the combination of these two remedies in the form of the well-known 'Antikamnia and Salol Tablets' affords us the ideal medicament for pain and fever in rheumatic conditions. Patients appreciate the fact that when administering Antikamnia you relieve the pain without giving them morphia, while the Salol acts as a germicide and antiseptic, tending to ameliorate generally the symptoms of the disease. Antikamnia and Salol Tablets (each tablet contains two and a half grains of Antikamnia and two and a half grains of Salol) are best given in doses of two tablets every three hours until ten or twelve tablets are taken during twenty-four hours. The patient's bowels must be kept open and the diet should be light. Alcohol is contraindicated and water should be freely and frequently given. The bed covering should not be too heavy, but warm. Cold water packs, as well as hot fomentations, are very beneficial."

**THE TREATMENT OF NASAL CATARRH.**—Mannon (*Cincinnati Lancet-Clinic*) finds no danger whatever from the use of the nasal douche, provided ordinary care is taken and a proper solution is employed. The charge that post-nasal douching is prone to excite inflammation of the middle ear, he does not find sustained. All leading specialists employ this method of treatment in the posterior as well as the anterior nares with equally good results. The doctor has had chronic nasal catarrh of many months' duration yield to douching when heroically employed. Listerine to which a small quantity of bicarbonate of soda has been added is his main stand-by. If hemorrhage is a controlling feature, he uses instead a saturated solution of tannic acid, to each ounce of which ten grains of carbolic acid has been added. When the tendency to bleed ceases, he returns to the listerine solution. Treated in this way, the most pronounced cases yield in three or four weeks, and are not prolonged by complications or sequelæ.

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**GLYCO-HEROIN (SMITH) COMPARED WITH CODEINE AND MORPHINE.**—Aside from the after effects of morphine—such as nausea, general lassitude, vomiting, and vertigo—it has the disadvantage that the patient becomes readily addicted to it, and chronic morphinomania occurs, especially in neurotic persons.

Codeine, in its physiologic action, resembles narcotine, though the narcotic stage is not so much pronounced. When administered in small doses intestinal peristalsis is promoted, while in large doses it produces diarrhea in consequence of complete relaxation of the intestinal muscles, owing to paralysis of the nerve centers governing the intestines.

• The sedative action of Codeine is unreliable.

Expectoration is not promoted by Morphine or Codeine, while Glyco-Heroin (Smith) acts as a stimulant to the respiratory center, and stagnation of the secretions is excluded.

Comparative doses of Glyco-Heroin (Smith) and Codeine show the latter to produce nausea, vomiting, and vertigo, while these symptoms are absent during the administration of Glyco-Heroin (Smith).

Unlike morphine preparations, Glyco-Heroin (Smith) does not constipate.

Glyco-Heroin (Smith), as a Respiratory Sedative, is decidedly superior to the preparations of opium, morphine, codeine, and other narcotics, as it is devoid of the toxic or depressing effects which characterize the latter when given in doses sufficient to reduce the reflex irritability of the bronchial, tracheal, and laryngeal mucous membranes.

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**McFARLAND'S TEXT-BOOK OF PATHOGENIC BACTERIA.**—In our notice of this most excellent work in our November, 1903, issue, we neglected to state that it was the *Fourth Edition*, although the notice states that it was a new edition and had been "entirely rewritten."

**MEDICAL PRESS EXHIBIT AT ST. LOUIS.**—A recent communication from Dr. Charles Wood Fassett, editor of the *Medical Herald*, St. Joseph, Mo., has the following:

"I have secured adequate space at St. Louis, in the palace of Liberal Arts, with a view to making a display of American medical publications which shall be commensurate with the importance of this class of work, and earnestly solicit the coöperation of editors and publishers of medical journals. Decisive action must be taken at once. The expense necessary to make this exhibit will be nominal. There is no charge for space, and I believe that the Department of Publicity will assist us in maintaining an up-to-date and comprehensive exhibit, where files of current issues of every medical journal in the land may be found during the progress of the great fair.

"Full information will be furnished later, and all medical journalists are urged to communicate *at once* with me with a view to united action and early endeavor, so that additional space may be secured, if necessary, to accommodate all who desire to join the bureau."

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**SEVERE SEPSSES SUCCESSFULLY TREATED WITH ENEMATA OF COLLARGOLUM** are reported by Dr. H. S. Loeb, of Schlesinger's Division of the Franz-Josef-Spital. During the last two years much therapeutic experimentation has been done in this division with Unguentum Credé and Collargolum. In some cases intravenous injections of the latter were found impossible on account of obesity or smallness of the veins. Collargolum enemata of  $2\frac{1}{4}$  to  $4\frac{1}{4}$  grains in  $2\frac{1}{2}$  ounces of distilled water were therefore administered twice daily for eight days, a cleansing enema being given beforehand. Besides two case histories, the speaker demonstrated the temperature curves of three severe sepses, a puerperal infection, and a thrombo-phlebitis following typhoid, in which the favorable results were doubtless due to Collargolum. In four cases the enemata had to be stopped, partly because of negative results, partly on account of other complications. No definite results were obtained in six feverish phthisis cases. The advantages of the enemata lie in their safety and simplicity and in ease with which the dosage may be increased.

In the discussion Dr. Frank highly recommended the intravenous Collargolum injections.

Prof. Hermann Schlesinger agreed with Dr. Frank, holding that Collargolum is a most effective weapon in septic conditions, especially when administered intravenously. Schlesinger has seen apparently hopeless cases saved by it. In his experience the rectal application was just as effective as the intravenous method.

(Abstracted from the Wiener klin. Wochenschrift, October 29, No. 44, 1903.)



## *Reviews and Book Notices.*

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**THE NEUROLOGICAL PRACTICE OF MEDICINE.** A Cursory Course of Selected Lectures in Neurology, Neuriatry, Psychology, and Psychiatry; Applicable to General and Special Practice. With 177 illustrations. After the Author's Class Room Methods as a Teacher of Students. Designed for Students and General Practitioners of Medicine and Surgery. By Charles H. Hughes, M.D., President of the Faculty and Professor of Neurology, Psychiatry, and Electrotherapy, Barnes Medical College. Former Major and Surgeon in Chief of Schofield, Winter, Hickory Street, and McDowell's College Military Hospitals, Superintendent Missouri State Insane Hospital, Acting and Honorary Member of Many Home and Foreign Medical and Scientific Societies, Etc. Member Governing Board of Centenary Hospital, ex-Member Board of Health, and Consultant of City Hospital, Insane Hospital, Etc. 8vo, cloth; 415 pages. Price, \$3. Hughes & Co., 418 N. Third Street, St. Louis, Publishers. 1903.

The Neurological Practice of Medicine is a cursory course of selected lectures, from an eminent source of clinical and lecturing experience, on the essential features of neurology, neuriatry, psychology, and psychiatry applicable to the general and special practice of medicine. The book is plainly and forcefully written in the author's well-known, impressive, and succinct style. Many of the pages of the book are peculiarly fascinating and eloquent, as well as accurately descriptive and scientific.

The style of the author in the amphitheater reappears in this remarkable book, as those who have sat under his clear and original teachings will discover in the reading of the several chapters.

The fruitful results of thirty years of extensive clinical experience over a portion of the vast fields of neurology and psychiatry are presented in this valuable book.

The psychiatric factor in surgical and medical practice, psychical depression and the neuropathic diathesis, post-operative insanity, etc., are some of the other and many remarkable features of this remarkable book, from a remarkable source of extensive and broad clinical observation and experience, reaching over a third of a cen-



tury of constant, varied, and wide medical practice, giving aspects of medical observation and reasoning from the neuro-anatomical, neuro-psychological, and neuro- and psycho-therapeutical side of medical observation, that is coming rapidly under the consideration of the profession and destined to prominently prevail in the future practice of medicine.

**A REFERENCE HANDBOOK OF THE MEDICAL SCIENCES.** Embracing the Entire Range of Scientific and Practical Medicine and Allied Science. By Various Authors. A new edition, completely revised and rewritten. Edited by Albert H. Buck, M.D., of New York. Vol. VII. Illustrated by chromo lithographs and 688 half-tone and wood engravings. Pp. 951. William Wood & Co., Publishers, New York. 1904.

The seventh volume of this magnificent work has just been issued, and in no way falls behind the preceding splendid volumes of this *complete* handbook. The series lacks only one more volume, and will make the most complete work for reference in any of the branches of medicine and surgery extant. This volume begins with "Saccharin" and ends with "Ulcer," among the many important subjects contained being the spinal cord, which is most fully considered in its anatomy, physiology, diseases, and injuries, the article on "Surgery of the Spine," being contributed by our fellow-townsmen, Paul F. Eve, M.D., Professor of Surgery and Dean of the Faculty in the Medical Department of the University of Tennessee. His brother, Duncan Eve, M.D., Professor of Surgery in Vanderbilt University Medical Department, also of this city, contributed the article on "Dislocations" in Volume III. The entire work comprises a complete medical library in itself, and is something more than a revision of Beech's "Handbook," nearly all of the articles having been entirely rewritten.

**PHYSICIAN'S VISITING LIST** (Lindsay and Blakiston's) FOR 1904. Fifty-third year of its publication. Seven different styles, ranging in price from \$1 to \$2.25. P. Blakiston's Son & Co., Publishers. Sold by all booksellers and druggists.

With this edition "The Physician's Visiting List" enters upon the fifty-third successive year of its publication. This is a record which tells its own story. The old veteran is on hand. In addition to the other valuable features for which it is noted, we wish to

call attention to the pages on incompatibility, chemic, pharmaceutic, and therapeutic, and the page on the immediate treatment of poisoning. "The Physician's Visiting List" is a pocket record book and ever handy reference guide for the medical practitioner. Neat, compact, well-arranged, and durable, it has justly earned so many friends throughout the medical world that commendation is unnecessary.

**PROGRESSIVE MEDICINE.** A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. By Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, etc. Assisted by R. M. Landis, M.D., Assistant Physician to the Out Patients' Department of Jefferson Medical College Hospital. Vol. III., December, 1903. 8vo, cloth; 444 pages. Lea Brothers & Co., Publishers. Philadelphia and New York. 1903.

This valuable digest in its concluding volume for 1903—Vol. IV., December—comes to us with all its former excellencies well maintained. The following is a brief summary of its contents: Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas, and Peritoneum, by John C. Hemmeter, M.D.; Anesthetics, Fractures, Dislocations, Amputations, Surgery of the Extremities, and Orthopædics, by Joseph C. Bloodgood, M.D.; Genito-Urinary Diseases, by William T. Belfield, M.D.; Diseases of the Kidneys, by John R. Bradford, M.D., F.R.C.P.; Physiology, by A. P. Brubaker, M.D.; Hygiene, by Charles Harrington, M.D.; Practical Therapeutic Referendum, by H. R. M. Landis, M.D. A full and complete index concludes the volume.

**THE WORTH OF WORDS.** By Ralcy Husted Bell, with an Introduction by Dr. William Colby Cooper. 8vo, cloth; 305 pages. Third Edition, revised and enlarged. Hinds and Noble, Publishers, 31-35 W. Fifteenth Street, New York. 1903. Price, \$1.25.

This little work should be in every public and private library, in every school, college, and university. For teachers and writers it is invaluable. It points out the many errors that are so common in speakers and writers. It covers a wide field, and is written by one who has evidently given the subject much and careful thought. The short chapter of about twenty pages, devoted to "Slang," is of more than passing interest. In its previous editions it has received the commendation of able writers and speakers.

**MEDICAL RECORD VISITING LIST FOR 1904.** William Wood & Co., Publishers, New York.

This "Visiting List" has always given the most complete satisfaction to all who have tried it.

A complete revision of the reading matter in the front part of the "List" has been made this year. The table of average doses has been carefully revised and brought up to date, all the newer drugs of importance being included. A novelty introduced last year for the first time into a "Visiting List" is the Obstetrical Chart. This will be found useful for making quick estimates of the probable duration of pregnancy. In all respects the high standard of manufacture, as to paper, printing, and binding, that has always distinguished the "Medical Record Visiting List" has been fully maintained.

**A NONSURGICAL TREATISE ON DISEASES OF THE PROSTATE GLAND AND ADNEXA.** By George W. Overall, A.B., M.D., formerly Professor of Physiology in the Memphis Hospital Medical College. 8vo, cloth; 217 pages. Illustrated. Marsh & Grant Co., Publishers, Chicago, Ill., 1903.

In presenting this book to the profession, the author has, by avoiding theoretical discussion, endeavored to give a plain, practical, and concise summary of the methods and results of nonsurgical treatment of diseases of the prostate and their sequelæ as demonstrated by more than twenty years' clinical experience.

Notwithstanding the brilliancy of its sheen and its work in the hands of an experienced surgeon, yet the errors of the knife being so often irreparable gives this little volume a peculiar value. And again it is not always that you can obtain consent for using the knife, and perforce are compelled to resort to other measures.

**THE AFTER TREATMENT OF OPERATIONS.** A Manual for Practitioners and House Surgeons. By Lockhart Mummey, F.R.C.S., England, B.A., M.B., B.C., Cantab, Demonstrator of Operative Surgery St. George's Hospital, and late Senior House Surgeon of same. 8vo, cloth; 221 pages. Illustrated. William Wood & Co., Publishers, New York. 1903.

The importance of the after treatment is by no means secondary—a most brilliant operation may be rendered ineffectual, and an almost hopeless one may round to under proper measures. The author has given us in this little volume a condensed mass of valuable, practical matter that is to be found in fragmentary form here

and there in the larger text-books on surgery, making it exceedingly useful for reference and study. We can and do most heartily commend it.

MEDICAL NEWS VISITING LIST FOR 1904. Lea Brothers & Co., Philadelphia, Publishers.

This excellent annual publication comes to us with none of its former valuable details omitted. It contains thirty-two pages of data likely to be needed by every practitioner, and blanks for recording all details of practice, both clinical and financial. It is issued in four styles: weekly, dated for thirty patients; monthly, undated, for one hundred and twenty patients per month; perpetual, for thirty patients weekly and sixty patients undated, and without the preliminary data for those requiring specially large record books. The paper, printing, etc., are of the best quality.

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## *Selections.*

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SALINE INFUSION.—This is the age of revelation. The veil which since the creation has separated the outer from the inner court of nature's great tabernacle is being drawn aside, and the mysteries of the holy of holies are being revealed. Seemingly impenetrable darkness has been pierced by the X-ray, and now the marvelous light of radium is peering still farther into the unknown. The world is learning that the kingdom of heaven is within us, and not in some distant realm. Substances which have been considered most simple and common, are found to possess properties of inestimable value. The medical fraternity is following close upon the heels of the scientist and the psychologist; and, beside making discoveries of its own, is reflecting all newly discovered light upon its own profession for the purpose of alleviating human suffering and bringing humanity into harmony with the laws of its creation. The newly discovered properties of "chloride of sodium" are proving to be among the most valuable and efficient agencies of our therapeutical remedies. It has been successfully used in the treatment of numerous diseases, such as habitual constipation, the alleviation of pain by the use of local applications, in

rheumatism, neuralgia, etc., but we wish to consider at this time its newly discovered therapeutical value in the treatment of conditions to which it has previously not been applied. Judging from the increased number of articles we see in our medical journals upon the subject, the use of "saline infusion" is growing in favor with the profession. The three principal ways in which it is administered are: the rectum, hypodermically, and directly into one of the larger veins. The rectum absorbs the solution promptly, and in cases in which the symptoms are not grave this is the proper route to select. From one or two quarts can be given every two hours until the necessary degree of intervascular tension has been reached. In graver cases the solution is administered subcutaneously, infusing from a pint to a quart at a time, and repeating the procedure every hour or two until a sufficient quantity has been used. In *very grave* cases, the intravenous route will yield the quickest and most reliable results. Ordinarily the median basilic vein is selected to receive the solution. It has been demonstrated that a high temperature, not lower than 120° F. is necessary to its highest efficiency, and according to Erkelenz the best results have been obtained not from the true isotonic nine per cent salt solution, but with the six per cent solution. Szuman recommends the addition of carbonate of soda, his "saline solution" being composed of

Sodium chloride.....	6 parts.
Sodium carbonate.....	1 part.
Distilled water.....	1000 parts.

The saline solution is at present most extensively used in diseased conditions associated with either hemorrhage or intense toxæmia. It replaces the fluid lost to the tissues in hemorrhage, and refills the blood vessels, thereby giving the heart something on which to work. It stimulates the cardiac ganglia, sustaining the nutrition of the heart itself, rendering it possible for the remaining blood to be propelled to the vital centers, holding the life forces until new blood can be formed. It relieves collapse, and raises the blood to normal temperature, but its greatest therapeutical power is manifested in lowering the specific gravity of the urine, in exciting diuresis and diaphoresis in all toxic conditions. It also dilutes the poisons circulating in the blood, and by the process of cell-lavage

removes the poison from the paralyzed cell, thereby bringing about a normal function. Permit me to detail a few cases in illustration of the value of saline infusion:

*Case I.*—I was called in haste to the bedside of Mrs. W. H. G., about eight miles distant; age thirty-eight, multipara, in the seventh month of pregnancy, with general anasarca from extreme uremia. The fourth convulsion had just passed when I arrived. I administered one-half grain morphine with the usual amount of atropine, hypodermically, and further controlled the convulsions by the rectal administration of hydrate of chloral. I then proceeded to bring on labor as quickly as possible, using hot saline injections against the os uteri, which I think assisted greatly in the dilatation. After delivery the patient had "sinking spells;" the face and hands were cyanotic, the arms and legs were cold, and other symptoms of approaching death were apparent. At this time I used the saline solution by enteroclysis, about a quart at a time, every two hours. The effect was wonderful. The pulse could soon be detected at the wrist, cyanosis disappeared, respiration became regular, consciousness returned. The kidneys responded nicely to the action of the saline infusion, and a surprising quantity of dark colored (almost black) urine was passed in the following twenty-four hours. I am quite confident that I owed the full recovery of this patient to the saline treatment.

*Case II.*—Dr. F. C., in the *British Medical Journal* of this year, cites a case of a four-year-old boy who had swallowed four ounces of undiluted whisky. Unconsciousness, shallow respiration, with a weak and rapid pulse, supervened in forty-five minutes—the general condition being one of profound collapse. As no vomiting had occurred, the stomach was washed out and the usual stimulation resorted to, without effect. Hot saline enemata were then introduced. The child recovered consciousness within an hour, and was apparently well the next day.

*Mercks Archives* (April, 1903) reports that a number of cases of bubonic plague were treated with chloride of sodium, the effect of which was to rapidly lower the temperature, the normal being often reached within twenty-four hours, and becoming subnormal three or four days later, and then normal again, under the continued use of this treatment. The buboes diminished in size, and sometimes disappeared. By means of the saline treatment the rate of mortality was reduced fifteen per cent.

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In July last two cases of severe sunstroke, in which the regular remedies were entirely ineffectual, were given the saline treatment. The temperature of the two respectively was 108 degrees and 109 degrees F., which ice caps and baths had failed to reduce, and both patients were delirious. At the rate the temperature was maintaining itself, it was a question of only a few hours when they would either become insane or die from exhaustion. It was in this emergency, and with so much at stake, that the saline solution was introduced, an heroic and novel measure. The result was magical. Within an hour one patient regained consciousness, his temperature falling four degrees. In the other case, soon after the infusion, convulsions ceased, and he fell into a deep sleep, with rapidly lowering temperature.

The credit for the first use of the salt solution hypodermically for the cure of pneumonia doubtless belongs to Dr. F. C. Henry, of Philadelphia. Dr. Maurice Kahn records a case of this disease in his practice, where the ordinary methods failed to produce any favorable change in the condition of the patient, who had a pulse of 160, temperature 105 degrees F., Cheynes-Stokes respiration, pronounced cyanosis, cold arms, legs, and forehead, and was apparently moribund. Hypodermoclysis was ventured, four injections, aggregating about three pints, being given within six hours. The immediate effect was astonishing. The pulse became slower and of better quality, the temperature dropped, cyanosis disappeared, respiration became regular, consciousness returned, a general mild perspiration superseded the dry skin, and diuresis was marked. For two days rectal injections of salt solution were given at intervals. The subsequent history of the case is of great interest. On the ninth day of the disease, as there had been no voice sounds nor rales for three days, with absolute dullness of the involved area acupuncture was performed. Result: dry tap. From this time recovery was slow, but on the whole satisfactory.

I have used saline solution in my practice in different ways, in varied diseases, and under varying conditions, with only gratifying results. I would recommend its use for the restoration of blood after hemorrhage from any cause, for shock with or without loss of blood, for collapse in the course of any disease, especially cholera and typhoid fever, or collapse following a surgical operation. In puerperal infections it increases the power of the tissue and blood



to resist the action of microbes, destroys them, and assists nature in throwing off their effects. Its use has also proved beneficial in cases of Epilepsy and of narcotic poisoning.

We have already learned that so simple a substance as our common salt has more in it than has been dreamed of, and its field of usefulness will no doubt be still farther widened and extended.—*H. C. Beckett, M.D., in Virginia Medical Semimonthly.*

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THE ORIGIN OF MALIGNANT NEOPLASMS.—F. de Quervain says that experimentation so far has shown that the existence of a parasite of cancer is not yet proved, and that clinical and experimental researches up to the present have only succeeded in establishing the inoculability of cancer by a "cellular graft," and not by a virus, outside living cancer cell. The theory of the parasitic origin of cancer, instead of explaining away all difficulties, gives rise to many new problems which are as difficult to solve as the development of a malignant tumor without the intervention of a microörganism. The search must be continued, but by means of experiments from animal to animal, and not from man to animal. This should be easy enough, because cancer is common in dogs and mice. First of all, one ought to find out whether cancer is transmissible by the cancerous juice, rigorously excluding in these experiments the transplantation of cancer cells. If one could thus discover the vehicle of the virus, it would make it less difficult to determine its nature.—*Medical Press and Circular.*

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THIALION.—In the treatment of these diseases by means of drugs, and I have given all of the accepted remedies a thorough trial, and I regret to say that I have been unsuccessful, except with thialion, and thialion I feel I cannot praise too highly, for in the way of medicine it has done more for my gouty patients—and when I say gout, I mean all cases of uric acid poisoning—than everything else put together.—*Extract from a paper published in the New England Medical Monthly October, 1899, by Henry S. Pole, M.D., Hot Springs, Va., member of the Virginia State Medical Society, etc.*

# Listerine

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**Absolutely Safe, Agreeable and Convenient.**

Listerine is a well-proven antiseptic agent—an antizymotic—especially useful in the management of catarrhal conditions of the mucous membrane, adapted to internal use, and to make and maintain surgically clean—aseptic—all parts of the human body, whether by spray, injection, irrigation, atomization, inhalation, or simple local application.

Listerine is a swift and sure destroyer of infusorial life; it prevents the various fermentations, preserves animal tissues and inhibits the activity, growth and motion of low forms of vegetable life: hence Listerine may be relied upon to destroy the activity of the living particles which constitute contagion whenever brought into intimate contact therewith.

**For diseases of the uric acid diathesis:**

## Lambert's Lithiated Hydrangea

A remedy of acknowledged value in the treatment of all diseases of the urinary system and of especial utility in the train of evil effects arising from a uric acid diathesis.

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## *Prescriptions and Formulary.*

### HEMORRHAGES IN TYPHOID FEVER.

G. A. Sheldon, in *Medical Standard*, recommends the following combinations to control the hemorrhages in typhoid fever:

R. Ext. ergotæ flu. ....m. x  
Morph. sulph. ....gr.  $\frac{1}{4}$   
Atropinæ sulph. ....gr. 1-150

M. Sig.: To be used at one dose hypodermically.

At the same time he administers 15 minims of a solution of adrenalin chlorid (1-1,000), and repeats it in twelve-drop doses every four hours.

As an intestinal antiseptic he recommends sodium sulphocarbonate. After the second week the following combination is given as an antiseptic and to allay as much as possible the tympanitis:

R. Olei terebinthinæ. .... $\mathfrak{z}$ ii  
Olei gaultheriæ. ....gr. xii  
Pulv. acaciæ. .... $\mathfrak{z}$ vi  
Syr. simplicis. .... $\mathfrak{z}$ ss  
Aquæ ..... $\mathfrak{z}$ vi

Misce and filter. Sig.: One dessert-spoonful in a little water every four hours.

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The adult dose of GLYCO-HEROIN-(SMITH) is one teaspoonful, repeated every two hours or at longer intervals as the case may require.

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---

To remove the sordes from the teeth and to cleanse the mouth the following is used:

- R.    Tinct. myrrhæ.....℥ iss  
       Glycerini .....℥ iii  
       Succi limonis.....℥ i  
       Aquæ q. s. ad.....℥ vi
- M.    Sig.: To be used as a mouth wash.
- 

## SWEATING OF THE FEET.

*Merck's Archives* recommends the following combinations in excessive perspiration of the feet:

- R.    Acidi salicylici.....gr. xv  
       Tannoformi .....℥ iss  
       Pulv. orris.....℥ i  
       Pulv. talci.....℥ ii

M.    Ft. pulvis.    Sig.: Apply locally; or

- R.    Formaldehyde .....℥ iv  
       Petrolati .....℥ ii  
       Lanolini .....℥ iv

M.    Ft. unguentum.    Sig.: Apply freely at night; or

- R.    Pulv. acidi borici.....℥ i  
       Pulv. amyli.....℥ iii  
       Tannoformi .....℥ ii  
       Olei caroph.....gtt. i  
       Olei lavendulæ.....gtt. iii

M.    Sig.: Use as a dusting powder.

# Bronchiline

INDICATED IN

**Bronchitis, Coughs, Laryngitis, Pneumonia, Asthma**

A valuable remedy in the treatment of all irritable conditions of the respiratory tract. Efficient and agreeable. Contains no Morphine, Heroin, nor any form of opiates ; gives prompt relief. Has been endorsed by leading physicians all over the United States for fifteen years, Formula furnished upon application. Prepared in 16-oz. bottle. Prescription price \$1.00. A full-sized bottle sent to any physician, prepaid, upon receipt of 50 cents in stamps, to cover expressage.

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**NEAT-RICHARDSON DRUG CO. LOUISVILLE,  
KY.**

## PRESCRIPTIONS AND FORMULARY.

In axillary bromidrosis the following is recommended:

- R. Creolini ..... ʒ i  
Ext. violet..... ʒ iv  
Alcoholis deod..... ʒ iii

M. Sig.: Wash the armpits with warm water, followed by an application of the lotion.

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### GONORRHEAL EPIDIDYMITIS.

- R. Retul-Ol. (Methyl-oleo-salicylate Co.) ..... ʒ i  
Ol. Amygdal. Dulc..... ʒ ii  
Misce fiat applic.

Sig.: Apply to the scrotum on lint and cover with impermeable silk and a suspensory bandage. Change the dressing every two hours. The absorption of the salicylic radical is easily proved by an examination of the urine.

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### CHRONIC DYSPEPSIA AND PHOSPHATURIA.

- R. Syr. Acid. Glycero-phosphatis Comp. (Huxley). ..... ʒ viii

Sig.: One teaspoonful diluted with a wineglass of water half an hour before meals, and

- R. Acid Arsenosi..... gr. i  
Pulv. Ignatiæ..... gr. viii  
Pulv. Rhei..... gr. xxxvi  
Pulv. Opii..... gr. viii  
Misce fiat capsul, No. 60.

Sig.: One capsule immediately following each meal.

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### CHOREA.

Malbec, in *La Médecine Moderne*, advises the following combinations in the treatment of chorea:

- R. Salipyrini ..... ʒ iiss  
Strontii brom..... ʒ v  
Syr. aurantii corticis..... ʒ ij  
Aq. calcis..... ʒ vj

M. Sig.: One teaspoonful in water after each meal.



# SANMETTO FOR GENITO-URINARY DISEASES.

A Scientific Blending of True Santal and Saw Palmetto in a Pleasant Aromatic Vehicle.

A Vitalizing Tonic to the Reproductive System.

**SPECIALLY VALUABLE IN  
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PRESCRIPTIONS AND FORMULARY.

FOR GONORRHEA.

The following combinations are recommended by *Merck's Archives* in the treatment of gonorrhea:

R. Methylene blue.....gr. xx  
Copaibæ .....℥ ii  
Olei resinæ cubebæ.....℥ ii  
Pancreatin .....℥ i

M. Ft. cap. No. xxiv. Sig.: Two before each meal; or

R. Largin ..... ℥ ii  
Aquæ destil..... ℥ vii

Misce, by using boiling water. Sig.: To be used as an injection several times a day; or

R. Largin .....gr. xv  
Glycerini ..... ℥ ii  
Aq. destil..... ℥ vi

M. Sig.: Inject three times daily for first few weeks, then once daily; or

R. Ichthargin.....gr. i-iv  
Glycerini .....℥ iv  
Aq. destil. q. s. ad..... ℥ viii

M. Sig.: Inject four to six times daily.

In cases of gleet and chronic gonorrhea the following:

R. Bismuthi subnit.  
Mucil. acaciæ, ā ā .....℥ iv  
Aquæ ..... iii

M. Sig.: Shake well and inject morning and evening; or

R. Methylene blue  
Pulv. myristicæ, ā ā .....gr. xl  
Dionin .....gr. x

M. Ft. capsulæ No. xx. Sig.: One capsule three times a day.

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**EDITOR AND PROPRIETOR**

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**NASHVILLE, FEBRUARY, 1904.**

**No. 2**

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### *Original Communications.*

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#### MEDICINE, PHILOSOPHICALLY TREATED.

BY GEO. H. TICHENOR, JR., A. B. (TULANE UNIVERSITY),  
M. D. (Tulane Univ.), Former Member Am. Historical Association ; Medical In-  
specter Louisiana State Board of Health ; Asst. Supt. Woodcroft  
Hospital, Etc., Etc., of New Orleans, La.

**Position of the Physician:** In view of the importance and elevated character of medicine, it has been looked upon with regard, esteem and even veneration, for history tells us that the ancient poets made Aesculapius to be the son of the sun—the fountain of health. Even the “Great Physician” made the body of man the object of His miracles. So from ancient times to the present day, the physician has been the object of attention either from the exalted position in which his admirers placed him or the fame or disrepute of his practice. If the fame of his practice does not live in history and fiction, it will in rhyme. Even Chaucer, Ben Johnson, Boileau and Coleridge

could not resist the temptation of expending their epigrammatic wit at his expense. Whether it was justly due him or that the greatest benefits are commonly received with the least gratitude, I shall leave to others to decide.

To-day he is looked upon by the masses as a kind of savant, knowing a little of everything, but not much of anything. He derives his knowledge from the schools of arts and sciences of the different universities, and gives his education a finishing touch at the medical department; still retaining (in the common mind) that talent for curing disease, which undoubtedly must meet with equal success, that his famous father possessed, who was a physician before him. And notwithstanding also that his license from the State permits him to practice the art and science of medicine in any and all its branches as he may consider proper, devotes his time and money to research for personal advancement and the good of the world, some seem to have the idea that he is biased and men with meager advantages understand by intuition the art and science better than he—not even granting that the stress of competition would lead him to employ such methods to the cure of disease which would be more advantageous to himself and patient. Alas! how degenerated from the lofty position of the olden times, when divine healing fairly oozed from his fingers! This prevailing notion of the masses has led to the founding of different sects that have adopted some mode of practice used by regular physicians for the cure of a certain disease or diseases for the cure of all. For instance, the practice of massage and manipulation, which has been used from the days of Hippocrates to the present day by professional masseurs under the direction of the physician, has lately led to the founding of the Osteopathic School.

**Object of This Essay:** So the purpose of this essay is to enable the student to understand the philosophy of the art and science of medicine as it is, and not as it is commonly mistaken to be. For every day the student is bewildered by seeming incongruities of thought and practice, and the appeals of the laity for the rebuttal of the doctrines of medicine's false prophets.

**Manner in Which the Subject Has to Be Treated and the Distinction of an Art and Science:** The first ideas in considering this subject that naturally come into our minds are, What is medicine? Who is entitled to call himself "Physician?" It is

probably best explained by what it is not. In dealing with this subject I shall confine my remarks to the theory and practice of the "Allopathic," or regular school, or "old school," of medicine. At the same time, I shall take into consideration that while the doctrine of disease and practice of medicine has varied in different ages and with different sects of philosophers and medicine, there are here and there expressed ideas through the ages which formed the basis for development—it was obscured and retarded, aided and suppressed in development, according to the fancy of religion, philosophy and politics.

**History and Philosophy of Its Development:** The history of medicine is more conceived as an aggregate of isolated, disconnected theories and practices than as an evolution. There have been mighty efforts and corresponding failures, and very slow advance towards truth. There are differences and contradictions, and many deviations from the principles laid down by Hippocrates to his guild which the student of medical history can perceive from the beginning to the end of the seventeenth century. While it is a true saying that whatever is in the realm of matter or ideas is continuous and based upon its antecedents, however changed or modified it may be, yet the medical profession did not know and accept a sufficient number of truths upon which to establish a basis for the evolution of the medicine of to-day until the beginning of the eighteenth century. The pathological anatomy of Rokitansky and Virchow; development of the methods of auscultation and percussion by Laennec; the antiseptic method of Lister; the chemistry and bacteriology of Pasteur; theories of disease as promulgated by Koch are of modern origin.

The history of ancient medicine up to the time of the establishing of the school of medicine at Salerno is one in which there is great speculation, for the only valuable records we have are from non-medical writers, as Homer, Arrain, Strabo and the physicians, Hippocrates, Galen and Celsus.

**Ancient Medicine:** The clippings from the ancient writers (poets., etc.) concerning the ability of their contemporary doctors, which have been collected and commented upon by many historians, are of no practical importance to the medical profession, for they give no valuable information. Their praise may have been just or influenced by their own delusion—we don't know. We know that the Greeks were of a too notionate disposition to have ad-

vanced very far in medicine. On the other hand, the Romans were not materially inclined to the arts and sciences, and what they did cultivate was obtained from foreign sources. Again, if the ancient nations had reached that degree of perfection which many think they did, we certainly would have had more advanced medicine taught at Salerno; even if only a few manuscripts were handed down, the art being an imperative one, the knowledge would have been kept in a great measure by oral repetition. But such was not the case. The only things that this period has given us are the principles of Hippocrates and the theory of evolution as proclaimed by Empedocles and his contemporaries, precursors of Darwin. There is no doubt also that from the very earliest times the knowledge of the healing powers of tissues were known, and the rudiments in the most elementary form of surgery, obstetrics and hygiene were understood. (See Herodotus, Euterpe 11, p. 125.)

Coming to the medicine of mediaeval Europe we find it crude and barbarous in the extreme, survivals of which are readily distinguishable in the medicine of to-day. We still speak of disease "attacking," "seizing," which smack of the old demoniacal theory of disease. You may say that such ideas belong to religion. But you must remember that in the beginning of human affairs everything presented a religious aspect. Even Epicurus (340 B. A. D.) attributed premature death to the evils, not due to the creation of the gods. It was not until the rise of the great universities in Europe that there seems to be any definite attempt at specialization in studies. From a very early day we can trace distinct differences of purpose only in the higher schools of learning, for example, Bologna law and Salerno medicine.

**Mediaeval Medicine:** The methods of the school at Salerno were unscientific and crude in the last degree. The works of Hippocrates and Galen, which, together with those of Aristotle, Plato and Euclid, were translated into Arabic in the ninth century, formed the basis of their medical knowledge; but the Arabian physicians did good service to medicine in introducing new articles from the East into the much-needed European materia medica, such as rhubarb, camphor, senna and cassia; and making the first elements of pharmacy and chemistry, adding such knowledge as that of distillation and the means of obtaining the metallic oxides and salts. Any knowledge of the working causes at this period could hardly be separated in the minds

of the people from the notion of opposition of the divine plan.

It was not until Western Europe let their thoughts go on the new fields of inquiry and break away from the teachings of the Greek scholars that settled in Italy and the Arabians in Spain, that the culture of to-day in medicine and other fields began to dawn. From the middle of the fifteenth century on medicine makes wonderful strides. In biology, the Belgian Vesale lays the foundation of the science of human anatomy; the Englishman Harvey proves the circulation of the blood, however previously advanced by the Spaniard Michel Serves, and the Italians, Realdo Colombo and Andreas Caesalpinus. There was an appreciable advancement made in this period until the French Revolution, after which medicine enters upon the glorious and triumphant period of to-day. It was during this period also that Joseph Priestly (1733-1804), theologian, philosopher and naturalist, and discoverer of oxygen, is the first to try to reconcile religion, materialistic philosophy and science with Christianity, and even Calvinism. The French great materialistic physician, Julien Offrey de la Mettrie (1709-1751), however, does not share in these illusions. The evolutionistic and transformistic conception familiar as we have seen to ancient philosophy reappears in various forms advocated by Denis, Diderot, Robinet, Charles de Bonnet, precursors of Lamarck and Darwin. Finally, on the eve of the Revolution, the physician, Cabanis, formulated the principles of psychological materialism with such vigor as has never been excelled, and proclaimed physiology and psychology the one and the same science.

The soil of Europe by this time was well fertilized by every variety of mysticism and quackery, opposing philosophy and schools of medicine, that appealed to the imagination and superstitious mind. As an evolutionistic period of nonsense which had existed during the mediaeval period we find flourishing the societies of Illuminate,, Rosicrucians, Alchemists and Occult Free Masons. Joseph Balsamo (B. 1743), necromancer, hypnotist and charlatan, being conversant with Mesmer and his theories, accomplishes some remarkable cures which are well attested, is an example of the product of the times. But he does not give the proper agents the power of doing the work—hope and expectation—which, in his case, where no remedies of medicinal value were used, must have been the products of imaginative and superstitious minds. He and oth-



ers of his class, who are less noted, are the precursors of Christian Science and other modern fakes. However, he was not the originator of the idea, as wise physicians have made use of this method from time immemorial. Charles of England performed his miracles with the same old instrument. For in olden times the King cured the King's evil by the divine touch of the royal hand—his valet could have done the same if he had been attired the same way.

**Modern Medicine:** From the French Revolution to the present day positivism dominates the scientific and literary fields. It is based solely on reality, on facts, on observation and on experience. The arts of surgery and Obstetrics now rest largely on the sciences of anatomy and physiology, normal and pathological pharmacology, which, as we have seen in the preceding period, could not have advanced very much owing to the late date of their formation and establishment. The development and progress of physiological chemistry, physics and biology, protected by freedom of thought, are the principal beneficent agents in modern medicine. Now theory and practice can go hand in hand, supported by science and maintained in its lofty position by the culture and Christianity of the day. Still it is not free from fancies and innovations of new prophets which will never come to pass. The revival of metal therapy (a curative method in which metals were applied to the affected area) by Dr. Burg in 1851 is an example. Mesmer, Perkins and Hahneman had previously advanced the theory. The theories of these three apostles of new creeds were developed more by the revolutionary spirit of the times than original study, and were not the products of a systematic application of the facts of medical art and science as existed at that time. Within the last century in America, several sects of curers have appeared under various names and have seemingly done some wonderful things in curing people without "substantial medicine," but not without "material coin." There are the Mind, Faith, Prayer, Mental Science, Christian Science and every other scientific cure except the right one. They all meet with some degree of success; but do not give the proper agent the credit of doing the work—the patient's imagination. The harm that they do is in deceiving the ignorant class. The society class of people who run after fads and fancies and anything new adopted by way of novelty and set it aside when real disease

makes its inroads upon them; but there are some who firmly believe in such nonsense, influenced by the class of people such doctrines are advocated by. Such people, when defeated in argument, refer the matter to the Bible, which is the shield, not only of the righteous and wise, but the sinners and ignorant ones. The days of such practices, though, are numbered. Culture is becoming too general. As for medicine, it has acquired such character and derived so much benefit by the progress and adoption of modern sciences that its practices are based upon knowledge gained by systemic observation, hospital and army records; its knowledge is co-ordinated, arranged and systematized; publications of societies and hospitals; also the prosecution of truth (as we have seen really had its commencement at the beginning of the eighteenth century), both in the abstract and as a historical development, though of but a short period.

Conclusions: Therefore medicine is making rapid strides in the direction of being a true science in the strict sense of the term. The wide diversity of theories and practices, such for example as those concerning practice as advocated by Hippocrates, Cullen and Thomas Sydenham, together with their results, sentimental and capricious ways of administration and the manner in which the medical profession has been a worshipper of men and their dogmas and fads will soon be a thing of the past. Uniformity, that mighty standard for men and things is being enforced. The study of medicine of to-day, deprived of all ideas of the supernatural, both as an art and science, gives the student that knowledge which enables him to predict the course of disease and direct and control its forces; besides that economic position in which he is able to use his talents to the betterment of the human race.

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THE NATURE AND GENESIS OF AN INSANE DELUSION.—J. W. Wherry, in the July number of the *American Journal of Insanity*, at the close of an article with the above title, thus defines an insane delusion: "This, then, is an insane delusion: an idea born in subconscious cerebration, projected into consciousness in times of stress; believed implicitly and strenuously defended by the originator, but which no one else will accept as true.—*Medical Age*.

## MYOCARDITIS:—A CLINICAL STUDY.

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Gentlemen:—This is practically a case report, so after giving briefly some general considerations of myocarditis that bear on the cases in question I shall ask you to assist me in untangling some knotted pathological and clinical threads which I have found in a particular type of myocardial affection.

Myocarditis may be either acute or chronic. I shall deal with the chronic variety alone. Under the name chronic myocarditis are included a number of morbid conditions and clinical pictures which, though differing widely in degree and nature, have yet this one point in common, that the ultimate result of the morbid process, and the one of paramount importance is a condition of cardiac insufficiency. Dispensing with those rather rare diseases of the myocardium, due to parasites as well as those due to neoplasms, pathological conditions of the heart muscle may be said to occur invariably as a result of one or more of the following causes: First, senile change; second, changes in the quality or quantity of the blood supplying the heart muscle; third, changes resulting from long continued functional derangement and strain.

Senile Change: The man who attains his allotted three-score years and ten without realizing that he has an apparatus to keep his blood circulating is an anomaly. And when the Psalmist concludes that "If by reason of strength they be four-score years, yet is their strength labor and sorrow, for it is soon cut off and we fly away," he utters, unconsciously, perhaps, a pathological and clinical truism. Every man in his declining years is necessarily a victim of disturbed circulation in some degree. The change in his heart muscle may so keep pace with the other signs of his advancing years as to be inconspicuous, for they may be so marked as to cause decided symptoms and demand treatment. "The heart is the one organ of the body whose sufferings are most apt to disturb the equanimity of the most imperturbable." We know that with each pulsation, life and intelligence are flashed to the farthest

outpost of our frame, and we also know that if the heart beats falter for a second or two we fall to the ground, pale, limp and almost inanimate—an almost which speedily becomes absolute if from any cause these heart beats are prevented from resuming their pristine vigor. With this knowledge ever before our eyes and clinched by many a startling fact, we cannot wonder that feelings of alarm are excited by any deviation from the normal which makes us cognizant of the movements of so important an organ, of which we are ordinarily so profoundly unconscious. Hence palpitation, intermission, irregularity and tremor cordis, all of which make themselves so disagreeably perceptible to our senses, appeal most forcibly to the imagination of the patient, and bring him more certainly to the physician than cardiac ailments of more serious import but of less obtrusive character. Symptoms such as those described always, and at every age, indicate some physical impairment, a matter of comparatively little moment in early life, but of very much more serious import after middle life. We must not forget, too, that at any age, but more probably in advanced life the physical impairment may be primarily due to failure of the trophic nerve centers.

Microscopically his heart may show varying degrees of fatty or other degenerations, fatty infiltration, hyperplasia of the interstitial connective tissue. One or all of these changes may be present in the heart at the same time, and while occurring as a result of irritation or malnutrition of the myocardium from some antecedent cause, become themselves causes of further impairment of nutrition and thus establish a vicious circle of interdependent and interacting factors of disease and decay. Inviting complications, they may cause death, or in themselves may become so extreme as to be fatal. Unless complicated by valvular insufficiency, anginoid attacks or some train of striking symptoms which suggest to the attendant a morbus cordis, the condition presents so few and such insignificant symptoms that a high percentage of cases probably pass undiagnosed, despite the fact that the great majority of people pass middle life who present indications of cardio-vascular disturbance have no valvular lesion and probably no symptoms which are strikingly suggestive of heart disease. But however insidious the onset and unobtrusive the manifestations, the progress is sure and soon or late the fatal termination occurs, perhaps suddenly and without warning or—non vi, sed

saepe cadendo—as more often happens, its advance is stealthy, hidden by the footprints of the passing years and making itself known by some vague symptoms only when the patient is already shrouded in the gloom of approaching dissolution. While every subject of senile change in the heart does not die as a result of that condition, it should always be borne in mind that an affection which might only embarrass and cripple the heart in a healthy man, may prove fatal in a man whose myocardium has undergone degenerative changes.

Changes in the Quality or Quantity of Blood Supplying the Heart Muscle: Under this head will come those cases of chronic myocarditis induced by insufficient blood supply resulting from disease of the coronary arteries, from impairment of the general circulation, as well as those cases resulting from the changes in the quality of the blood; namely, (a) deficiency in the nutrition of the blood, and (b) the presence of toxic substances in the blood. Any of the above-named pathological changes may result from these causes, giving rise to the same symptoms that occur with degeneration of the heart muscle from any cause.

Long continued functional derangements and strain bring about chronic inflammation of the heart muscle by causing hypertrophy, dilatation, impairment of nutrition and continued disturbance of the nervous mechanism of the heart.

Whether one or all of the above causes act in producing myocarditis, and whatever the morbid changes present, the symptoms manifested are exceedingly variable and distressingly unreliable. Any attempt to associate a certain train of symptoms with any one of the above morbid changes is worse than useless. A patient with a fibroid heart may present practically the same symptomology shown by a victim of extreme fatty degeneration. They may both have few or no symptoms, or, on the other hand, may suffer with the most striking manifestations of extreme cardiac disability. The symptoms most often found are feeble, irregular pulse, often slow, dyspnoea, sometimes anginoid pains, and when relative insufficiency complicates the above disease the symptoms of this condition are superadded.

The inadequacy of the morbid changes to the symptoms and termination of some cases will be strikingly shown in the following brief case reports. During the summer of 1902 I was called to see Lucinda H—, aged 49, who complained of slight

dyspnoea and occasional precordial oppression. The patient gave no history of rheumatism, syphilis or alcoholism. She had, indeed, been an unusually healthy woman and a hard manual laborer. For the last few months she had been bothered by occasional attacks of palpitation and paroxysmal dyspnoea. For a week or two the dyspnoea had been worse and more or less continuous. Some dropsy was present, but the most striking symptom was the arrhythmic pulse, which was irregular in force, intermittent, rather soft, with fifty beats to the minute. The arteries were somewhat firm. On physical examination the apex beat was neither visible nor palpable.

The woman had emphysema, was obese with a thick chest wall, consequently no enlargement of the heart could be made out. On auscultation the first sound of the heart was weak. The aortic and pulmonary second sounds were accentuated. No murmur was detected. Under the influence of digitalis the heart's action became more forcible but did not become regular. I beg you to bear this in mind—the patient grew steadily worse and after some weeks died. Being so fortunate as to secure the privilege of an autopsy, the following observations were made: Both the right and left sides of the heart were somewhat hypertrophied. The valves and their orifices seemed to be normal and competent. The heart muscle appeared to be healthy except along the course of the coronary arteries and auriculo-ventricular furrows, where there were decided increases in the sub-epicardial fat with some infiltration of the adjacent muscular tissue. The morbid changes certainly did not seem extensive enough to have produced fatal termination, since no obstruction was found in the cardiac vessels. My ante-mortem diagnosis was fatty degeneration; after the necropsy I had none. With this problem still unsolved, I saw case number two. A man of 55, a hard worker, an alcoholic, who complained of some precordial distress, at times anginoid in character. He got progressively worse, particularly palpitation and attacks of syncope.

The heart's action began to get weak and irregular. At this time his pulse was only fifty-five to the minute. This condition lasted for some weeks, gradually becoming more marked and the patient died after a prolonged attack of palpitation. When first examined his heart impulse was moderately forcible, the apex slightly out to the left, the aortic second sound

was accentuated, no murmur was present. During the last weeks of his sickness his heart became weak and he developed dyspnoea and other signs of cardiac failure. The heart muscle responded to digitalis by an increase in the force of its systole, but the pulse remained irregular and this condition became very marked as the case neared its termination. The post-mortem examination revealed no incompetency of the valves. The coronary arteries were rather firm, but no more than was to be expected from this general arterio-fibrosis, which probably accounted also for the moderate amount of hypertrophy. The muscle was fairly healthy, but showed an increase of interstitial connective tissue in patches in the apical region; and of particular interest were some areas of fibroid degeneration seen in the upper part of the right ventricle, near the angle of the auriculo-ventricular and inter-ventricular grooves on the surface of the conus arteriosus.

Neither this nor the previous autopsy had shed much light on the diagnosis. Indeed the pathology and the clinical findings appeared to be at cross purposes.

I was confronted by the incongruous picture of two patients who had died evidently of heart failure, but who did not show sufficient degeneration of the myocardium to account for their untimely end, and in whom no indication of angina pectoris, valvular disease or disease of the coronary artery was to be found. Chagrined and vexed at this enigma, the more I pondered on the two cases the farther at sea I was. While in this state of dissatisfaction I received a letter from a friend in a charitable institution. He wrote as follows: "A strange coincidence which occurred yesterday taught me a lesson which I shall never forget. Two patients died in the hospital; one an old woman with phthisis, died of severe hemorrhage from the lung. At the autopsy we found a heart dilated excessively. The cardiac muscle had undergone fatty degeneration to such a degree, that in places one's finger could almost be pushed through it, and we are puzzled because she had presented practically no symptoms of this condition. The next patient, a man who labored on the place, had been apparently well except for occasional attacks of syncope, slight dyspnoea at times and a peculiar, irregular pulse, beating only forty times to the minute. I have just seen his heart and find nothing abnormal except a fibrous nodule about the size of a buckshot near the root of the right coronary artery."



A critical study of these cases will reveal the following striking points common to three of them:

First, such slight changes in the cardiac muscle as to appear entirely inadequate to the fatal termination, unless acting through some other way than mere insufficiency in contractile power of the muscle, for the muscle not only appeared at the post-mortem to be of good color, firm and healthy but responded to digitalis, as shown by the increased force of systole which degenerated heart muscle would not have done. This point is emphasized when the three cases are compared with the greatly degenerated but apparently serviceable heart of the old woman who died of hemorrhage. Immediately we begin to cast about for some auxiliary cause of death, and the second observation possibly puts us on the right track. Bradycardia and arrhythmia were present in two of the cases, possibly the third and did not disappear under digitalis. Briefly stated, the significance of these symptoms appears to me to be this, they stand as exponents of derangement of that delicate nervous mechanism which constantly equalizes the contending impulses going to the heart, and brings about that admirable balance of function resulting in the normal cardiac cycle. "For, while the heart beats because its muscular fibre is incompletely differentiated and still retains power of spontaneous movement possessed by all primordial protoplasm, and while the heart's energy resides in its muscular fibre, and its quality depends upon the perfection of the cardiac metabolism, still it is true that the nervous system, though neither initiating nor maintaining the rhythmic movements of the heart, does control and regulate, and through it these movements may be variously modified and even arrested. The earlier observers, Adams, Richard Quain and Stokes, endeavored to connect sequentially a slow heart with fatty degeneration of the myocardium. But the very antagonism of the two symptoms precludes the idea of the connection of them being anything but purely accidental. Indeed, a similar statement may be made with regard to atheromatous conditions of the heart, aorta or coronaries, as well as all other cardiac and vascular affections with which a slow pulse has been found incidentally connected. These lesions are all so much more frequently found apart from a slow pulse than with it, that it seems much more reasonable to conclude that the apparent connection is merely accidental, than that there is any direct connection

of the one to the other. This is quite distinctly the case, even in the only lesion which is always present in every case of senile bradycardia—dilatation and hypertrophy, the dilatation predominating. Slow pulses are rare, but after middle life, as has been shown, dilatation and hypertrophy of the heart are of every day occurrence. As to the cause of slow heart, we know that many poisons, both organic and inorganic, bile, uremic poison, diphtheria toxine, lead, etc., slow the heart, but these all have a direct action upon the nerves and nerve centers. Indeed, all the information present at our command seems to point to direct action on the spinal accessory nerve in the neck or chest before or after its junction with the vagus, whether by concussion, compression or otherwise as undeniably the most potent and probably the only cause of abnormal or pathological bradycardia." The inference gotten from this is so strong as to be obtrusive. Clearly we must look to the nervous mechanism of the heart for the unknown morbid factor in the cases quoted.

The branches from the sympathetic, vagus and spinal accessory nerves which unite to make the cardiac plexuses, descend on either side, crossing the aorta and forming below its concavity in front of the right pulmonary artery the anterior cardiac plexus. Passing down close to the pulmonary artery near the roots of the coronary arteries, they lie on and become imbedded in the highest part of the right ventricle, the main branches spreading over the conus arteriosus and ramifying in the horseshoe-shaped region bounded by the diverging coronary arteries. Indeed, so rich is this region of the heart in nerve tissues that an authority states that it is difficult to decide which predominates, muscles or nerves. We say then that the agency by which the cardiac movements are controlled consist of a network of nervous filaments, covering the surface of the heart, particularly at its base. This network is connected with various nervous ganglia scattered through the substance of the heart, particularly at the junction of the sinus venosus with the auricle and in the auriculo-ventricular sulcus. I beg you to remember that at these points, the auriculo-ventricular sulcus, the region of the conus arteriosus, the root and first portion of the coronary arteries, where the main cables of this vital telegraph system lie, were found the fibroid nodule the size of a buckshot, the patches of fatty degeneration and infiltration at the post-mortem. As to their significance, from

the pathologist we learn that "degeneration of the intercardiac ganglia has been noted by a number of observers in myocarditis, and in cases of angina pectoris without gross cardiac alterations. The changes observed are swelling or granular, fatty and hyalin degeneration of the ganglion cells and infiltration of round cells with sclerotic formation between the nerve cells. The importance of these changes has not been determined." This brings us to the gist of the whole matter: Can areas of degeneration adjacent to the first portion of the coronary arteries, which the main nerve trunks follow, or patches of fibroid tissue in the regions mentioned as so rich in vital nerve centers and fibres so deranged or abolished the function of the adjacent nerve matter by pressure, impeded circulation or otherwise as to bring about such results as have been detailed in these cases.

What a field of speculation this opens to us, who may measure the pressure exerted on a sensitive nerve center by a hard, contracted mass of fibroid tissue; who shall say, when the blood supply is stopped by squeezing fat cells, how the starving fibre fails in its duty! Ah! what exquisite agony does it experience in the dying, this quivering, fragile nerve cell, and, lastly, gentlemen, who shall picture the lightning flash that, thrilling through every fibre, prescient of the approaching end, signals to each waiting atom of paling flesh, it is finished?

I am aware, gentlemen, that I am open to criticism, likely to be called theoretical, impractical; but then, theory is only the formulated question which the pathologist later puts in a material way. Speculation has ever preceded investigation. And when such unexplained cases confront me, my inquisitiveness, unduly great, perhaps, awakens and from the depths of the unknown sounds a Momnonian voice, saying in no uncertain tones, "Why, why?" and will not be stilled.

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## SOME VIEWS OF SHOCK IN ABDOMINAL OPERATIONS.

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Shock is "sudden vital depression, due to an injury or emotion which makes an untoward impression upon the nervous system."—Dorlan.

In this paper I shall take up and deal with each phase separately.

It is, of course, well understood that weak, anaemic and asthenic patients, everything considered, are most liable to shock as a usual thing, but this is not an invariable rule, as some strong, robust patients of unstable nervous systems are very prone to suffer under the stress of any abdominal or other operation. In the former class they should, where time and circumstance permit, be built up and their general condition improved, and in both cases all the encouragement and mental quietude possible given. A strong hope of, and determination to recovery is worth much in our prognosis.

The immediate preparation for operation is very important. The bowels should be thoroughly emptied and the kidneys made active where time permits. It is a bad plan to give a drastic and depleting purgative the night before an operation. It is much better to give active purgation two days before date of operation, then keep the bowels clean with high enemata given once or twice daily after, placing the patient on rich, concentrated fluid diet until the morning of operation, thus allowing him to react from the depressing effect of the purgation and get the nervous tension relaxed, and, of more importance, get a night's rest undisturbed by purgation, where pain is absent, and if nervousness alone provokes sleeplessness give small dose of Brom. Sodii. During this time encourage the patient to drink freely, up to within a few hours of the operation, of a pure water, and on the morning of operation give a cup of strong coffee. Milk and other fermentable diets should be carefully avoided, and where fermentative conditions are present intestinal antiseptics are of use, given during the two days of preparation.

The patient should have daily baths with friction where premissible, and aside from this the operative toilet should be delayed until the morning of operation. A soap poultice should be applied from 6 to 8 a. m. (two hours) removed, the abdomen shaved and thoroughly scrubbed with soap and brush, and a wet bichloride pack applied until time of operation—at say 10 to 11 a. m.

Mayo has recently called attention to the lessened amount of infection when preparation is made not too long before operation (as in strangulated hernia) and deprecates shaving the abdomen the previous day. This also has a good influence in preventing the constant mental worry or unpleasant re-

minder, during the night previous to operation, which alone may produce sleeplessness, leaving the patient worn and unrefreshed in the morning.

Patients usually stand operations done in the morning slightly better than in the afternoon, and are often free from pain and get some refreshing sleep the following night if the morning hours are selected.

The remaining toilet, aside from catheterization, which in nervous patients may also be deferred, should be completed after anesthetization. The selection of anesthetic is of no mean importance, but as there are many considerations which should govern this, I shall not consider that further than to say if properly administered in cases where there are no contra indications (which are often in the surgeon's mind), I regard chloroform as nearest the ideal anesthetic up to the present state of anesthetic discoveries.

As to the operation per se:—The room should be above 90 degrees F.; the patient well covered and kept dry.

The shortest time commensurate with thorough, careful work gives the least shock. To my mind this ostentatious show of deliberation one often sees, needlessly delaying the operation and prolonging the anesthetic, is an unpardonable abomination.

It is often said "a long incision heals as quickly as a short one," and while true in a sense, should not be too lightly regarded. The longer the incision, the more tissue divided, the greater the injury to nerves, blood and lymphatic vessels, the more fibrin ferment liberated, and the more shock produced. An incision should be large enough to do the given work though without unnecessarily delaying the operation, complicating the procedure, causing rough handling of organs or undue traumatism to abdominal wall by bruising or stretching, but unnecessarily large incisions add their small quota to shock through the sources mentioned and by exposing a greater surface of the peritoneal cavity and should be deprecated. The parietal peritoneum should be carefully guarded against being stripped loose from the abdominal wall. The importance of this should be evident to any one familiar with the condition of shock following very slight injury to this sensitive gatherer of reflexes.

The importance of careful avoidance of hemorrhage is too obvious to mention. Every organ and coil of gut not demand-

ing inspection should be kept carefully tucked away in the abdomen with hot, moist gauze pads, if need be, to prevent exposure to atmosphere or handling; where exposed they are best not touched even with sterile pads. This careful avoidance of handling the intestines, where not imperative, cannot be too much emphasized, for we occasionally see patients in whom even the slightest handling will produce intestinal paresis, shock and great distention. The secret of this avoidance is to know the landmarks of the abdomen and the best routes of approach, and how to recognize the different organs by sight or touch, and how to read the "sign posts" found at different points in the abdomen.

In all manipulations a careful and consistent avoidance of traction or continued tension on any mesenteric attachment during operation, and of equally or greater importance is the avoidance of tension on the visera or peritoneum by sutures or ligatures placed during or after operation.

Again, the much discussed and often perplexing question of irrigation, I will not discuss further than to say where the whole abdominal cavity is not already affected, I avoid irrigation, and where done, it should be with a solution of not less than 110 degrees F., as a too cool irrigation quickly depresses.

In dealing with large fluid accumulations, either ascitic, cystic or Dermoid tumors, the fluid should be withdrawn not too rapidly, as the sudden relief of intra-abdominal pressure may suddenly cause dilatation of abdominal vessels, and as surely bleed the patient to death "in his own veins," as if the blood were escaping externally, and thus either causing death or prolonged and frightful shock. The immediate filling of the abdomen with normal saline solution and lowering the head, as in "Trendellenberg" position, is the best means of meeting this accident.

Pain is a potent factor both in the production and prolongation of shock, and looking to this, all instruments should be sharp, making smooth cuts and incisions, which causes less after pain, gives less serous exudate, hence less wound tension and local distress, as well as less likelihood of infection and quicker union.

The patient, in leaving the operating room, should be well dried and wrapped in blankets to prevent chilling of body, and the bedroom should be warm, 80 to 90 degrees, until all shock

has passed off and the anesthetic is recovered from. The bed should be warm, and external heat applied by means of hot water bags or bottles.

A high rectal injection of two scruples of hot saline solution with one ounce of whisky just before the patient leaves the table, given in "Trendellenberg" position, is always of advantage in combating shock and thirst, and given in this way is practically always retained, which is not the case if given after the patient is put to bed.

It is well in given cases to anticipate shock by giving strychnia before the anesthetic is administered.

In all cases it is, of course, understood that every measure to secure asepsis is absolutely essential.

Most of these measures every one recognizes and practices. Some seem small and trivial, but they add their quota to the clinical entity called shock, and some of them are too lightly regarded by many operators, but as sometimes a little thing may turn the scale and mean the difference of life or death to the patient, to say nothing of comfort after the operation, we should regard nothing whatever too small that will, in any measure, contribute to the desired result.

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## HEADACHE AND BACKACHE OF MENSTRUATION.

BY CHARLES A. DUNHAM, M. D., OF JACKSONVILLE, FLA.

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So overwhelming is the majority of women and young girls to-day who suffer from "headache and backache" as the frequent precursor and constant accompaniment of the menstrual period that there is considerable danger of our being forced to the unwise and unsatisfactory conclusion that such symptoms may be but normal and physiological; and, if this view should be accepted, the physician doing so is in further danger of being led to the course of offering only such temporary relief as may be obtained from the use of sedatives and anodynes. Naturally, he will consider that his duty is done if he succeeds in obtunding the pains during the time in which they necessarily occur, thus enabling the patient to pass through the ordeal with greater ease and comfort.

But experience has abundantly shown that the victims of this fallacious mode of treatment sooner or later become slaves to the calmative effects of the drugs employed; and, not only



are they afforded no really permanent benefit, but are continually rendered more sensitive to their sufferings. In short, the locking up of the secretions and retention of waste solids, resulting from the frequent taking of analgesic medicines, invariably aggravate the abnormal condition of affairs, which has been at the base of their troubles from the outstart.

There are to be noted, of course, varying degrees of intensity in the sufferings of these women—e. g., from the two or three days of slight frontal or temporal headache to the week of intense migraine, with its accompanying vertigo, distressing eye symptoms and gastric disturbances. In the former class of cases the processes of elimination (which are so essential at this time) are almost equal to the necessities of the occasion, and, were it not for a slight constipation or other excretory check, not even the temporary headache and depression would be noted; in the other, however, the sewers of the system are more effectually blocked, the circulation becomes charged with obnoxious waste, and the serious chain of symptoms arises which indicates the retention of this debris in the blood and which we now believe to be the true source of the evils we are considering.

To the painstaking study and investigations of Haig, of London, more than to those of any other authority, are we indebted for the knowledge which we now possess concerning the influence of uric acid in the causation of disease; and many disordered conditions of the system which were hitherto but little understood are now attributed to this factor while the therapeutic results founded upon this knowledge have been very gratifying. It is now generally recognized and understood that migraine is caused by the retention of this substance in the circulation, and that the solvent and eliminative mode of treatment, which aims at its removal, is the only one which promises or effects a really permanent cure.

We are indebted to Haig for the important discovery, that, two or three days prior to menstruation there is a marked diminution in the excretion of uric acid, that the latter substance is retained in the circulation until the second or third day of the flow, when it is excreted in greatly increased amount. This is what normally happens when the organs of elimination are healthy and active and perform this added duty properly, the only symptoms to indicate this temporary retention being a slight headache and depression of spirits at



the beginning of the period. But if, for any reason, elimination is imperfect, as is so frequently the case, uric acid remains to accumulate and we have all the disagreeable symptoms which are known to arise from its presence in the capillaries in excess.

It is evident, that in order to avoid this troublesome condition of affairs, it is the duty of the physician when confronted with such a case, to aid the patient's organs of elimination in removing this waste substance from the body at the time when such aid will prove most efficient—i. e., just previous to and at the beginning of menstruation. In short, it would seem that the increased work demanded of liver, kidneys and bowels, at this interesting physiological period, is often greater than can be satisfactorily performed, and, as a result of this partial failure, we meet with the many symptoms indicative of the presence in excess in the blood, of waste toxins of the uric acid type.

To illustrate the value of the solvent and eliminative mode of treatment in these cases, and the marked therapeutic advantages it possesses over the older palliative means usually employed, we cite briefly here the clinical outlines of a case of menstrual "sick headache" recently treated by both methods, to wit:

Mrs. W., aged 32, a slender brunette of decided nervous temperament, married and mother of four children, had for several years complained that for three or four days prior to each monthly period, she began to suffer intense headache, which warned her of her approaching sickness, and which necessitated complete withdrawal from all household duties. She was obliged to retire to a darkened room and remain in bed, while absolute quiet reigned. At the beginning of the menstrual flow, gastric disturbances arose (vomiting, etc.), the head symptoms increased in virulence, the entire surface of the body became cold and the patient relapsed into a semi-comatose condition alarming to her friends as well as to her physician. Vigorous rubbing of the limbs and body was always resorted to as a necessary means to restore what appeared to be "suspended animation." Brandy and the usual restoratives were applied.

The patient would recover from one of these attacks or seizures, remain in a very weakened condition for a short time and suddenly relapse into another attack lasting for an hour

or two. After remaining ill in this way for a week, the patient, upon the gradual lessening of the menstrual flux, would cease to have further attacks, but still remain very weak for two or three days. Upon recovery, she went about her household duties as usual for a fortnight, only to repeat the same experience at the coming monthly period.

The treatment in this case had consisted of the taking analgesics (antifebrin, etc.) at the onset of the headache, drugs of this character seeming to be her only refuge from the intense suffering at this time. After the commencement of her "spells," attention was directed solely toward restoring consciousness and feeling and an impeded circulation. It was evident, however, that some rational course of treatment should be adopted between the attacks to prevent their recurrence, as the patient was extremely nervous, and her general physical condition undermined. The chief symptoms of which she complained between times were constipation and occasional headaches.

After several years of this suffering and many changes in the treatment at the hands of various physicians who had been consulted, the diagnosis of migraine was made and the solvent and eliminative mode of treatment adopted. Instead of obtunding the pain by means of drugs which paralyzed nature's efforts at eliminating toxic waste, it was decided to directly aid in these efforts by stimulating the natural process of excretion and employing a solvent which would render removal of the urates prompt and certain; for it was now believed that the serious symptoms in this case were entirely attributable to the retention of colloid urates in the circulation and consequent choking up of the capillaries.

A day or two prior to the time of the expected headache, she was given, the first thing upon arising in the morning an hour before breakfast, a teaspoonful of thialion dissolved in a glassful of hot water, which dose was repeated at two-hourly intervals until four teaspoonfuls had been taken. This caused copious evacuation of the bowels and well marked diuresis. For the ensuing three or four days, only the single morning dose was taken. Though menstruation had now begun, yet the alarming "spell" which had always hitherto accompanied it, had now degenerated into a slight headache and some vertigo. She passed through the dreaded week with nothing more serious.

The same plan of treatment was adopted at the next period, while occasional doses of the solvent were taken in the interim sufficient to cause fairly free movements of the bowels. The result was even more satisfactory than before. A mild headache was the only symptom. This plan has since been followed regularly for the past three years, and, during all that time, the patient has failed to suffer one of her old attacks—passing through the monthly ordeal with comparative ease and comfort.

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## *Abstracts.*

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### SOME NEW TOPICAL AGENTS IN THE TREATMENT OF TUBERCULOSIS IN THE LARYNX.\*

BY SOLOMON SORLIS-COHEN, M. D., OF PHILADELPHIA.

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I have ventured to bring before the Association accounts of recent observations and cases yet incomplete, in the hope that some of the fellows might be induced to test in their practice certain agents and methods, which have seemed to me to be of use in the treatment of tuberculosis of the larynx, and that thus a more extended experience, and one, moreover, without personal bias, might be available for deciding upon the value of the treatment proposed. That many cases of tuberculosis of the larynx go steadily from bad to worse, in spite of our best efforts, is an experience unfortunately too common. On the other hand, some of us, at least, have seen cases in which there was no doubt of the correctness of the diagnosis of tuberculosis of the larynx, and in which healing has taken place surprisingly and unexpectedly.

During the past year I have, however, seen good results, alike in infiltrative, ulcerative and vegetative cases, from the use of the treatment here mentioned, namely: Formaldehyde with Protonuclein insufflation.

Beginning with the weakest solution of formaldehyde, the strength of the application is increased as rapidly as possible by successive increments up to 40 per cent. of the commercial

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\* Extract from the New York Medical Journal.

preparation, which equals 4 per cent. of pure formaldehyde. This is the strongest solution I have found necessary to employ. The indications for increasing the percentage of active drug are the ability of the patient to bear the applications, and the absence of inflammatory reaction.

After applications of formaldehyde, Protonuclein has been insufflated. The applications are made twice weekly. In the intervals the larynx is cleansed with a spray of hydrogen-dioxide solution, followed by insufflation of Protoneuclein, once or twice daily.

Case 1.—Sept. 13, 1895, I was consulted by Mr. G., a merchant, aged 27 years. His voice was evidently produced with great difficulty, was frequently lost altogether during attempted conversation, and was of a peculiarly hollow quality. He stated that hoarseness and difficulty of speech had been constantly increasing since Jan. 1st. Previous to that there had been no trouble. Cough, however, had persisted for five or six years, and in January, 1890, he had been sent to the West Indies, where he remained for four months, and returned, as he thought, well. On his outward trip he had had a hemorrhage aboard the steamer, and had had hemorrhages at intervals since which he had attributed to "heart disease," and, indeed, physical examination of the chest showed his heart to be greatly hypertrophied, there being regurgitation both at the aortic and mitral orifices. There was no history of lues. Laryngoscopic examination showed both vocal bands swollen and reddened. An irregularly lobated mass, probably as large as a large bean, projected from the meso-arytaenoid fold, preventing closure of the vocal bands. The epiglottis and arytaeno-epiglottidean folds were intensely red in color, but normal in contour. Physical examination of the thorax revealed the signs of a large active cavity in the middle of the right lung, and in the left lung considerable consolidation of both upper and lower lobes, with a small active cavity in the former. The expectoration was profuse, and the sputum contained tubercle bacilli in great numbers. The local treatment consisted, first, of interdiction of attempts at the production of the voice, conversation to be carried on in a labial whisper. Sprays of a weak solution of hydrogen-dioxide, followed by insufflations of Protonuclein daily, and applications of formaldehyde, gradually increased from 2 to 10 per cent. of the commercial (40 per cent.) solution, were made to the arytaenoid

mass twice a week. By the 9th of November the vocal bands had become normal in appearance, and the mass had been reduced in size fully two-thirds when injudicious and unusual exercise on the part of the patient precipitated a hemorrhage, followed by a pneumonitic attack, in consequence of which he was confined to the house, and intermission of active local treatment necessitated until about the 15th of December. The spray and insufflations were, however, resumed soon after the acute fever had subsided, and applications of guaiacol were made once or twice to ulcerations, which made their appearance at the base of the left arytaenoid cartilage. After Dec. 15th, and until Feb. 3d, full treatment was resumed and continued as previously with the effect of securing almost entire disappearance of the vegetation by the time above noted, when the patient sailed for the West Indies. He remained in Barbadoes during March and April, the spray and insufflations being continued by his wife, but no applications of formaldehyde being made. On his return, a few weeks ago (May 2d), no trace of the original growth could be seen, but a new growth about the size of a large split pea had developed above the right vocal band at the base of the right arytaenoid cartilage. The vocal bands, which had been of normal color at the time of his leaving Philadelphia, were quite red. Treatment was resumed and has been continued as at first. The redness of the vocal bands soon disappeared, and the new growth is becoming much reduced in size. The general health of the patient, which had been steadily running down after his hemorrhage, has been much improved by his trip. Whether or not the new lesion will prove as amenable to local treatment as the former one, I cannot say. The patient is still compelled to whisper, as the production of voice is difficult, owing to mechanical interference by the new growth with the action of the vocal bands, in addition to which there seems to be thyreo-arytaenoid paresis.

Case 2.—A man, aged about 26 years, seen at the Philadelphia Hospital, had been attacked with tuberculosis of the larynx during an ordinary slow tuberculosis of the lung. The epiglottis was characteristically thickened, and had begun to ulcerate, two deep fissures being present on the laryngeal face. The vocal bands were thickened and red, and ulcerations were present at the base of the left arytaenoid cartilage. Under treatment similar to that described above the ulceration

healed, the vocal bands became normal in appearance, the voice improved greatly, and the epiglottis had been much reduced in size at the time the patient removed himself from treatment.

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### CASE OF TUBERCULOSIS.\*

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BY HUNTER MCGUIRE, M. D., L.L. D., OF RICHMOND, VA.

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Miss P., of Abingdon, Va., was brought to my private hospital Nov. 9th, 1895. She had a hacking cough, enlargement of the glands of the neck, and consolidation of the apex of one lung. I diagnosed phthisis pulmonalis, prescribed constitutional remedies, and advised her being taken to some more suitable climate for the winter.

Before she could make arrangements to leave the hospital she had a severe chill, followed by high fever and a very sore throat. In a few days she developed a typical case of noma, or cancrum oris. The disease attacked her left cheek; and when the slough separated, an opening was left as large as a silver dollar, exposing the teeth and rendering feeding difficult. There was high fever, typhoidal delirium and great prostration.

The wound was cauterized and disinfected, and heroic measures used to feed and stimulate the patient, but the symptoms grew worse, and little hope of recovery was given to the relatives.

Finally, as a last resort, I began the use of Protonuclein, giving the tablets internally and dusting the powder on the wound. An immediate improvement followed, and after a long and trying convalescence the patient was able to return home.

A year later she returned to the hospital to have a plastic operation done to lessen the deformity of the scar, and when she first entered my office, I scarcely recognized the healthy, vigorous woman as my former tuberculosis patient. The enlarged cervical glands had disappeared, her lungs were clear, her cough was gone. She had been cured of tuberculosis. I have no explanation to offer for the result, but trust the clinical fact may prove of interest to the pathologist.

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\* Extract from an article in the Bi-monthly Bulletin of the Univ. College of Med.

## *Clinical Reports.*

### CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

MEETING HELD DECEMBER 7TH, 1903.

The President, Dr. James Hawley Burtenshaw, in the chair.

#### ERYTHROMELALGIA.

Dr. J. C. Lynch presented a patient suffering from red, painful extremities. About four years ago the patient had severe burning pains, first in the right and then in the left foot. The pain was intensified by standing or walking, and several months later he noticed that the painful areas were red and swollen and that the back of the great toe was violet after exertion. Two years ago the middle toe of the left foot was amputated because of the great pain. The toes of both feet are red; over the metatarsophalangeal articulation the skin is of a violet hue; the superficial veins are prominent and the parts are painful to pressure, but do not pit. When the feet are elevated the congestion disappears, to return when the feet are dependent. Sensibility and thermal sensation are not disturbed. The patient's condition improves during the cold weather.

The speaker said that the pathology of this condition is not well understood. Weir Mitchell considers it a vasomotor disturbance. It is probably due to peripheral neuritis of the branches of the plantar nerves associated with diseased blood vessels. Most of the cases so far recorded have occurred in men during middle life. Long hours of standing, associated with hard work, worry and exposure to various temperatures are important causative factors. Various infective diseases, such as gonorrhoea, malaria, syphilis, may also be important factors. It also occurs as a symptom in certain organic diseases of the central nervous system.

Erythromelalgia may be counfounded with Pick's erythromelia and the stage of local asphyxia of Raynaud's disease. In erythromelia there is a circumscribed reddening of the skin,



- followed by venous dilatation, confined to the extensor surface of the extremity. There is absence of pain and increased surface temperature and no change on altering the position of the extremities. In Raynaud's disease, 80 per cent. of those afflicted are women. It begins with local ischemia; pain may be absent or acute; it has no relation to position; it is unaffected by season. In many cases the symptoms are brought on by cold. It is anesthetic to touch, surface temperature is much lowered and there is symmetrical gangrene.

#### GENERAL PARALYSIS OF THE INSANE.

This patient, also presented by Dr. Lynch, illustrated the promptness with which the luetic poison attacks the central nervous system. The patient, 27 years of age, had a sore on the penis, which was cauterized, and he was given "pink tablets." This treatment made him much worse and he consulted another physician, who gave him black ointment to rub in every night. He continued this for about three weeks, when his eye became sore and painful and he consulted an oculist, under whose care his eye improved, but his throat became affected. The oculist sent him to another physician, under whose care he remained for about three months, when he lost his voice. He then consulted a specialist on the throat, and continued under his care until he became demented. The essential features of his disease are that it began with a series of epileptic seizures, on recovering from which he was affected by temporary aphasia and paralysis, which disappeared in a few days and was replaced by marked mental impairment. The mental condition gradually improved until he was prostrated by another seizure. He cries continually, wants to go to school and is unable to answer any questions intelligently.

Dr. W. B. Pritchard opened the discussion, saying that, in his opinion, the difference between Raynaud's disease and erythromelalgia is one of degree and sometimes symptomatic, but that the essentials of the conditions are identical.

Dr. M. Packard said that these cases are much more common than is ordinarily supposed. He had seen seven of them in the Polyclinic Dispensary during the preceding summer. The pathology of erythromelalgia and Raynaud's disease is practically the same, being an obliterating endarteritis. They are all due to contraction, as Mitchell showed in 1870. Two



cases of this nature in Dr. Sach's clinic developed into gangrene. In Raynaud's disease the pain is stabbing, while in erythromelalgia it is constant. Several cases of erythromelalgia were sent from the Hospital for Ruptured and Crippled with a diagnosis of flat-foot, owing to the character of the pains, and while these patients may have had flat feet, treatment by the Whitman brace only irritated the condition, due to the pressure it exerted. Cold water and potassium iodide proved effective, but the most successful agent in dilating the arteries was nitroglycerin.

Dr. Pritchard, in referring to the second patient presented by Dr. Lynch, said that he would like to call attention to a point of much interest to neurologists in the development of general paresis. Twenty years ago, if a diagnosis of general paresis was made, it was safe to assume that the patient could not live more than two years, but to-day it is reasonably certain that he would be alive ten years from the date of the diagnosis. For this transformation the speaker knew of no explanation. Another point of interest is that some years ago, before it was safe to make a diagnosis of general paresis, the patient must have shown some symptoms of grandiose delusions, but to-day nearly 50 per cent. of the patients suffering from this disease are without any delusions of grandeur whatever, and the condition is gradually tending toward a type that will be relatively free from such delusions.

#### EPILEPSIA LOQUAX.

Dr. Pritchard presented a patient suffering from this condition, aged 45 years. He said this was the only case of the kind he had ever seen. About nine years ago the patient began to suffer from attacks of vertigo and sudden pallor, the first of which was brought about by a shock. These attacks continued at irregular intervals for five years, when, at the onset of an attack, a spasm of the face was added to his other symptoms. He has continued to have these attacks with increasing severity and frequency up to the present time, when they assumed the type he proceeded to describe; the patient's face becomes very pale, twitching begins over the left eye (a few years ago the twitching had been over the right eye and it had been transferred to the other side of the face); then the muscles of the whole face begin to twitch, the hands become fixed, and a most profuse diarrhoea of speech follows, with perfectly dis-

tinct articulation continuing for a minute and a half. This is followed by characteristic semi-coma lasting for an hour or two, and the man's condition becomes normal. There is absolute loss of memory from the occurrence of some incident preceding the pallor until the awakening. The center of explosion in such cases, it is assumed, is in the region of the center of speech (Brocas convolution). Usually epileptics do not talk, yet this patient's only evidence of epilepsy is in his talking.

Dr. D. S. Dougherty said that while he had charge of the Epileptic Wards at the New York City Insane Asylum, Ward's Island, one patient would have seizures in a corner, remain rigid for a moment, and then talk incessantly for two or three minutes, have a slight twitching, fall, and the attendants would put him to bed and he would sink into a natural slumber.

#### ANEURISM WITH VERY UNUSUAL COLLATERAL VENOUS CIRCULATION.

Dr. Morris Manges presented a patient for Dr. Lynch. The man was 48 years old with the following history: He complains of pain through the chest and backbone, which is intensified on pressure. He first noticed this symptom six months ago, and it was followed, three months later, by pain over the heart and dry, brassy cough. Ten years ago he had a typical chancre. Physical examination reveals a large mass occupying the upper right part of the chest, which on palpitation is seen to have some expansile pulsation. On either side of the middle of the abdomen there is a double set of enormously dilated and tortuous veins representing a caput Medusae. Nor is this the only evidence of pressure; some of the upper veins are enlarged, also the veins of the back, especially on the left side. There is also a marked enlargement of the veins of the upper extremity, less marked on the left side. Examination of the heart shows the apex beat to be in the sixth space. Over the tumor nothing would lead one to suppose it was an aneurism except the slight expansile pulsation. One hears nothing except the heart sounds sharply accentuated. Deep palpation behind the episternal notch is negative and Oliver's sign is absent. In a case of this kind one would naturally think of an aneurism, of a gumma or other neoplasm. A new growth can be eliminated on account of the situation of this enlargement and the conclusions given. The question of gumma may be elimi-

nated because of treatment, the patient having had iodides without any results whatever. Considering the history, the only inference would be that it is a case of sacculated aneurism filled with an enormous amount of blood-clot. As to the collateral venous circulation, one's first conclusion would be that something is obstructing the iliac veins. The speaker had recently seen two cases beginning with either obstruction of the portal circulation or of the inferior vena cava. He had seen a number of cases of obstruction of the portal circulation and of the vena cava, but ascites had been a more or less pronounced feature in most of them. The marked venous collateral circulation in this case could be explained only by the presence of a large mass compressing both superior and inferior cavae. This would be caused by the presence of a large aneurism of the ascending aorta, of which the external evidences are to be seen in the sternal tumor. The fact that there are so few symptoms is caused by the aneurismal sac being filled with a very thick layer of organized blood-clot.

Dr. R. H. M. Dawbarn said that this case was particularly interesting because of the anastomoses. He had never before seen so typical an instance of the caput Medusae. He said that there were a dozen ways whereby the venous blood may, in obstruction of the portal vein's exit pass the liver and re-enter the inferior vena cava. In his opinion, a more important one of these in accounting for the caput Medusae than the instance mentioned by the speaker is the circulation from the liver to the belly wall, through the reopened umbilical vein of fetal life. In about 20 per cent. of such cases this cord again becomes a vein. In the case of the patient before the society, he thought that perhaps a small gumma of the liver in the region of the portal vein might account for the venous distention. Much larger doses of potassium iodide must be given before one could eliminate it as a cause. The fact of it being an aneurism would point somewhat toward tertiary syphilis, but so frequently is the cause of producing atheroma of the arterial walls. He did not consider the absence of ascites, even with great portal venous stasis, as effectually destroying the diagnosis of a gumma of the liver.

Dr. Albert Kohn said that he was impressed with the lack of symptoms of aneurism, even though the mass was filled with blood-clots. Pulsation was very slight. The hypertrophy of the heart might be explained by arterial sclerosis of specific

origin. Undoubtedly there was pressure on some of the larger trunks supplying the upper extremities, but before making a diagnosis, it should be considered that the treatment had not proved anything. The patient should have iodides in increasing doses, up to 100 or 200 grains a day, or even more, and injections of bichloride of mercury and salicylate of mercury. Very often injections of mercury will give results when iodides have absolutely no effect.

Dr. Packard suggested that the venous varicosities on the chest and abdomen were due to pressure on the internal mammary vein, with an anastomosis of the superficial epigastric.

Dr. Manges said that he still thought it was an aneurism. If it were a gumma also it would have eroded the ribs or the sternum.

#### DISPLACED LIVER AND KIDNEY.

Dr. Kohn presented a case of displaced liver and kidney. The patient, when she first appeared at the clinic, two years ago, gave a history of what was then diagnosed as colelithiasis. The gall-bladder could be distinctly felt. Some time ago she again presented herself, and on examination the liver was found to extend down to the umbilicus and the dullness to begin at the eighth space. On making a slight palpation over the edge of the liver the gall-bladder was found beneath the edge. The kidney could be felt displaced into the right iliac fossa. The entire process had occurred within the last two years.

Dr. Brooks H. Wells said he had had a similar case in which a diagnosis of fibroid uterus had been made. Upon examination, the upper edge of the liver was found to be two inches above the umbilicus. He made a median incision from the lower edges of the liver, got hold of the round ligaments at its incision into the liver, passed a suture of kangaroo tendon over it, so placed that it could be pulled back and forth, and then pushed the liver into its proper place. The patient made an uncomplicated convalescence.

#### GALL-STONE ILEUS.

Dr. Manges presented specimens from this case. The patient was a man of 58, who, a few months before had had an attack which his physician had considered to be appendicitis. About

a week before he was seen by Dr. Manges he had abdominal pain and severe attacks of vomiting at irregular intervals, and there was no movement of the bowels for about a week. On the day he was seen he had a movement following cathartics and enema, but in spite of this the vomiting, which by this time had become more or less constant, did not abate. The vomiting was characteristically fecal. There was no fever, nor was there at any time evidence of jaundice. Examination of the abdomen revealed nothing but a vaguely defined mass in the right hypochondrium. There was no increased peristalsis nor was there any evidence of distension. The introduction of a stomach tube brought up very large quantities of fecal material, acid in reaction. A fairly thorough lavage gave the patient great comfort for twenty-four hours. Recurrence of the vomiting, however, on the following day rendered exploration for an unrelieved abdominal obstruction advisable. The operation was performed by Dr. Lilienthal, an incision being made over the right side of a vaguely defined tumor in the right hypochondrium. A pus cavity was encountered and in this area a number of various sized gall-stones were removed, followed by drainage of the wound. The patient's condition at the time of operation had been desperate and was not improved by the operation, death occurring on the following day. At the autopsy one very large stone and several smaller stones were found high up in the duodenum, the largest stone over an inch and a half in diameter, practically filling the duodenum of the lumen. Very dense adhesions bound down the gall-bladder and duodenum to the stomach. The gall-bladder was very much thickened, and at its lower portion was a large opening communicating with the duodenum. It was through this opening, undoubtedly, that the stone had escaped into the duodenum. Dr. Manges closed his presentation with a brief discussion of the rarity of gall-stone ileus and some of the feature of its differential diagnosis.

The paper of the evening, on

ACUTE EDEMA OF THE LUNGS SECONDARY TO ETHER  
NARCOSIS, RECOVERY.

was read by Dr. V. C. Pedersen, who said, in part: The patient was 30 years old, healthy. Immediately after a thirty-minute administration of ether for an operation for piles, he developed acute edema of the lungs which very nearly proved

fatal. The induction of anesthesia caused great excitement and muscular rigidity in the extremities, which persisted about ten minutes. During that time the ether was administered rather freely but not excessively, in so far that less than four ounces was poured into the cone during the entire operation. The clinical picture of the edema was made up of profound cyanosis followed by cardiac weakness, but was not accompanied or followed by any mucus in the mouth, nose or throat. The resuscitation was accomplished by free use of cardiac stimulants, notably strychnine, whisky and nitroglycerin and of respiratory stimulants, like atropin and elevation of the foot of the bed. General, dry cupping of the chest was also instituted, and after about one hour of constant work over the patient recovery took place, without, however, the appearance of any fluid in the throat from the lungs. No later lung complications occurred.

The speaker stated that some twelve cases of a similar nature have been reported in medical literature, all of them fatal, and many of them showing, as in this case, an insidious onset at the end of the operation, notwithstanding the fact the anesthetization had been without incident. He thought this case worthy of publication for the reason that it illustrated the fact that certain persons are individually very susceptible to ether-fumes, the gas being irritating to the lungs. He therefore holds that whenever any difficulty appears in the early stages of anesthesia with ether, great caution and deliberation should be exercised in overcoming them. He stated that, in his opinion, aside from the very important factor of individual susceptibility, this case of edema may have been due to somewhat undue exhibition of ether early in the narcosis, although, after all, the total ether exhibited (less than four ounces) proved that this excess had not been very material.

Dr. Pedersen also presented a chloroform dropper which he had designed with the purpose of regulating the size of the drop allowed to flow from the tube which was inserted in the stopper. A large, small or medium drop could be allowed to fall on the mask, and at more or less frequent intervals, according to the desire of the anesthetist.

He also exhibited a new device for attachment to Bennett's ether apparatus, designed to greatly facilitate anesthetization in cases of operation on the larynx and trachea.

Dr. T. L. Bennett opened the discussion of Dr. Pedersen's paper. He said that pulmonary edema, following the administration of ether, is not a common occurrence. He had seen three or four cases in which this condition had been present in lesser degrees than in the case reported by Dr. Pedersen. The morbid anatomy of pulmonary edema is very likely that of congestion of the lungs, similar to that seen in the pleural cavity. Some patients are susceptible to pulmonary edema, as, for instance, those inclined to congestion of the lungs or those having tuberculosis. The anesthetist should be on his guard to notice any failure of the left side of the heart, either from weakness or from complications of the aortic valves or from aortic stenosis. The congestion from ether is usually sudden, but the edema may be quickly developed or it may not become apparent until the administration is stopped. In the case reported by Dr. Pedersen, partial edema of the lungs probably occurred during the early administration of the ether, and when the ether was stopped, a certain amount of stimulation was withdrawn, and the consequent depression favored the development of the edema. Whenever, during inhalation, the patient presents symptoms of cyanosis, he should be examined for edema, notwithstanding that his inhalation may be free. There is usually a rapid pulse, and the patient, if in an excessive case, will expel mucus from the cavities. In the treatment, prophylaxis is the most important feature. The ether should not be pushed so rapidly as to set up this congestion. The anesthetic should be changed as soon as the first symptoms are noticed, and it should be given in very small quantities, so that the patient may cough or vomit and so expel what is in the lungs. Strychnine should be given for stimulation. Artificial respiration, with oxygen, preferably, does much to start the circulation and may expel the fluid from the chest and lungs.

Dr. Pedersen said that he thought the choice of an anesthetic should depend to a great extent on the personal equation. He had recently administered ether to two patients who had suffered from bronchitis previous to the time of operation. The anesthetic, in both instances, had been chosen by the operator. The first patient was given ether, and developed a bronchial pneumonia, but did not die. The other patient was a man for whom the operator requested chloroform. Ether



was administered but he became cyanotic and chloroform was substituted. He got through the remainder of the operation without difficulty and made a good recovery.

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### SOME "CLINICAL EXPERIENCE."

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BY JAMES H. POWELL, A. M., M. D.,

Professor of Principles of Medicine and Clinical Medicine, Barnes  
Medical College.

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How often are we not called upon to prescribe a tonic to build up or otherwise reconstruct one of our run-down patients? In the one case the subject may be a convalescent from one of the many acute diseases; in another case the patient may be afflicted with a disturbance which seems to continue in spite of our therapeutic agents, and the sick man not return to his proper state of health simply because his system lacks that *vis a tergo* so important an adjuvant towards turning the scale in the direction most eagerly desired by the medical attendant. In each of this class of patients the indications point to the use of an agent with tonic properties.

To meet the requirements, the Pharmacopoeia proffers us many bitter preparations with recognized tonic properties, which physicians are wont to prescribe. In this line are found quinine, iron and strychnine, the calisaya compounds, columbo, quassia, gentian and many others less used. From a personal use of the tonic compounds extending over a period of sixteen years, I have found one in particular that has for a great many years found a very warm place in my prescription book, regarding whose therapeutic properties time and again have I received such pronounced and highly brilliant results that my efforts to call specific attention to Gray's Glycerine Tonic Compound will not be amiss.

I wish to state in the beginning that there are indeed very few remedies that rank as proprietaries that have claimed my attention during my sixteen years' experience. My mind was first directed toward the high plane upon which this remedy stands during a consultation several years ago in a very serious case of typhoid fever, wherein the patient appeared to be in a state of impending collapse due to frequency of the bowel movements, which the usual line of astringents seemed unable to control. The consultant, very much to my surprise.



suggested the use of Gray's Tonic given alone in dessertspoonful doses in water every three hours, and the abandonment of every other drug. To say that I was astonished is stating the matter very mildly, but to my later amazement following a few doses my patient improved perceptibly as evidenced by the lessened number of the discharges, and the subsidence of the apparent moribund condition, the tongue becoming moist and the pulse, temperature and other factors manifesting the most remarkable change for the better, the patient eventually convalescing without a single drawback.

Following this happy introduction to the remedy, it is not strange that I should have at once resorted to the preparation in a large number of cases. Without dividing my experience into numbered cases which in order of merit would be an impossibility, I will say that I have obtained fine results with this product in the treatment of tuberculosis subjects.

This is a class that particularly reject almost any of the regular pharmacopoeial products because of gastric irritability, but in every instance where I have used Gray's Tonic the product has been retained and even relished by many of my patients. I can recall a lady, whom I had been treating for uterine disease, present herself with a cough and a feeling of great weakness. Although with a perfectly normal temperature, and a pulse ranging from 78 to 84, I found, upon examination of her right lung, consolidation, which upon microscopical examination of her sputum showed not only the pneumococcus or diplococcus of Fraenkel but also staphylococci and a great many tubercle bacilli; these latter were scattered throughout her sputum, which was gone over very carefully. She was given creosote internally and Gray's Tonic in tablespoonful doses in a half a glass of water before each meal. Her improvement was marked, her cough materially relieved, and her expectoration reduced to a minimum amount. She is still under my treatment but I expect from the satisfactory way she is progressing, a complete restoration to her former health.

One of the most pronounced advantages I have ever obtained from the use of the remedy in question, occurred in my practice about five years ago. The case in question was a policeman, about 40 years of age, a married man who had a well developed case of locomotor ataxia. The well known efficacy of potassium iodide in such cases induced me to admin-

ister the drug in ten grain doses in saturated solution three times daily, but I soon found that the drug could not be tolerated. I disliked to give up the iodide, and accordingly thought of giving the drug in Gray's Tonic. I was indeed most agreeably surprised not only by its being tolerated, but by seeing well marked improvement in the patient, which continued over a period of about three months. Later, however, the disease returned with even greater persistency, and carried off the patient. Since using this preparation, however, as a vehicle for the administration of potassium iodide in this case I have been induced to prescribe the remedy in every instance where I give the iodides, and have noted that I obtain much better results, and much better tolerance of the iodides than formerly. In the treatment of constitutional syphilis there is no better prescription that can be resorted to than giving iodide of potash in Gray's Tonic, for the reason that while the patient is coming under the influence of the specific salt he is obtaining the beneficial influence of one of the most reliable tonics known to medicine, and accordingly the palpable results follow as a natural consequence.

In diarrhoeal and dysenteric evacuations, five grain doses of subnitrate of bismuth given to a couple of teaspoonfuls of Gray's Tonic will secure results very far superior to the astringent class of remedies. Of course it often happens that the intestinal tract must be swept out thoroughly with a dose of *Ol. Ricini* or magnesium sulphate, but whenever this plan of therapy is followed with the bismuth and Gray's Tonic these troublesome conditions will be found to yield most promptly and efficiently.

Several months ago I was called to Foley, Lincoln County, Mo., to consult with a physician in the case of a gentleman who had just passed through what was said to have been typhoid fever. I found on my arrival at the house that the gentleman was a mere shadow of himself, and what was more had a slight cough free from expectoration. An examination showed the lower lobe of his left lung posteriorly in the third stage of pneumonia, the rale redux being well marked. I learned that his temperature fluctuated each day some two degrees, and that the gentleman did not regain his strength in the proportion desired by his physician. Five grain doses of iodide of sodium was ordered in Gray's Glycerine Tonic Compound and the external surface of his chest corresponding

to the affected lung was painted with tincture of iodine. A liberal diet was also ordered for the patient, and under this plan of treatment a letter received from the attending physician advised me that the patient's recovery was quick, and most gratifying both to the Doctor as well as the family.

In the treatment of tonsillitis I am especially partial to the efficacy of sodium benzoate, and my favorite formula in the use of this excellent therapeutic agent consists of fifteen grain doses given in Gray's Tonic and the liquor ammonium acetatis. In the vast majority of cases, especially of an acute nature, the tongue is invariably covered with a coating more or less conspicuous, and as a result anorexia is a pretty constant factor. So common indeed is this condition that the usual question put by his patient to the Doctor is: "What can I eat?" The reason this question is so often asked is due to the fact that the patient has no desire to eat anything, and believing this an abnormal occurrence desires to acquaint the physician with the facts. Gray's Tonic when used in our prescriptions then meets most admirably this requirement, as under its tonic and reconstructive properties the patient's tongue will clean, and co-incidentally the desire for food will return.

In all acute diseases I rely to a very great extent upon warding off an attack of pneumonia by the strictest attention to keeping the mouth clean, and the tongue in the best possible condition. I have learned from experience that Gray's Tonic affords the best recourse for the prevention of these undesirable complications, and accordingly I use the remedy pretty freely in all diseases. Sometimes I add five drop doses of dilute muriatic acid to each dose, especially where the digestive system is much impaired, but wherever the Tonic is employed I invariably obtain the most satisfactory results.

What I have stated in this article applies to cases in general, for what is true of one case is likewise applicable to many of like conditions wherein I have resorted to the remedy and obtained the identical results. Sometimes, 'tis true, the remedy was used alone, at others it was used in addition to other staple compounds, but in any case the results obtained have been the deciding power in assigning virtues to Gray's Glycerine Tonic Compound. These results have been pronounced and stamp the product as a very superior and beneficial therapeutical agent.

## *Records, Recollections and Reminiscences.*

### WHAT SPOKE?

BY REV. JAS. H. MCNEILLY, A. M., L.L. D.,  
Late Chaplain, C. S. A., of Nashville, Tenn.

The thirty-ninth anniversary of the battle of Nashville brings up in mind vividly some of the experiences of those memorable days. One of my experiences, on the second day of the battle, was so remarkable as a psychological mystery that I am tempted to write of it for the Practitioner. I have repeated the story often to friends, but I have hesitated to put it in print lest its strangeness should cause a doubt as to its truthfulness.

On the 15th day of December, 1864, when the battle opened, my regiment, Forty-sixth, Forty-ninth and Fifty-fifth Tennessee Infantry consolidated, was camped at Compton's Hill, on the Hillsboro road. The total number we could muster was thirty-five, for we had been almost exterminated at Franklin. The result of the day's fight left us with only six men. I always went with the assistant surgeons into action, as I was chaplain. On the 16th as I had no special place I started to the quarters of the surgeons on the Franklin road, and walked leisurely along the line of hills called the Overton Hills, I think. The Federals were cannonading our lines with field guns, and two or three times I had narrow escapes. After a while I got a fine position to view the field, and directly Gen. Hood and staff came near, and for some time watched the progress of the battle. I was probably a hundred yards distant from them.

I stood just back of a little knoll, so that part of my person was protected, but I was so near the top that half of my body was exposed, and I could see over the hillock. Back of me was a steep ravine, in which were some ordnance wagons.

For a while the shells from the enemy's guns were quite frequent in passing near me. But soon the fire seemed to be concentrated on Gen. Hood and staff, and they had to move. During this time I suppose a hundred shells passed over and near me; but somehow I never felt that I should be struck.

Then suddenly I heard the peculiarly vicious hurtling of a shell, and at once there was on my mind an impression as vivid as if a voice had spoken, "Get out of the way, or you'll be killed." So strong and urgent was the impression that I sprang with all my might blindly away. The ground was wet and slippery, and I fell full length on the side of the knoll; at the same time the shell struck the top of the knoll, and I was covered with gravel and mud. I heard some of the wagoners shout: "The parson is killed," but I was on my feet in a moment. The moving away of Gen. Hood caused the shelling of that point to cease. I was so impressed with my close call that I determined to find out how close it had been. So I went and stood right in the tracks I had left when I jumped. The shell struck the top of the knoll and cut down a little sapling on the opposite side of the ravine, so that its course was plain. If I had not moved the shell would have struck me full in the breast.

Now the question—What made that impression on my mind? Why was I indifferent to maybe a hundred shells and so intensely concerned about that particular shell? Was it a mere coincidence? Was it the result of a mental state gradually becoming more acute in its sense of danger until it culminated in a real vision of the approaching shell? Was it an act of the subconscious mind, which saw the shell coming? I personally believe in the Bible and in the statement therein of angelic agencies as instruments of God's providence. And so I believe that some unseen angelic agency spoke to my spirit in that brief moment. How spirit may act on spirit I know not. But the fact I believe. At the battle of Shiloh a soldier, for the first time exposed to the terrible fire, and much frightened, uttered a prayer which I had frequent occasion to indorse: "Oh, Lord! Direct these bullets." He could direct me out of the way of the bullets as well as direct them.

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DR. T.J. CROFFORD, of Memphis, Tenn., reports a case of extrauterine pregnancy in which the gestation sac was so thoroughly developed and so strong, that it was enucleated without the loss of any blood. The sac was completely intact all around the fetus. He supposed it to be a parovarian cyst, but after the sac was slit open out came the fetus.—N. Y. Medical Journal.

## *Obituary.*

### DR. JOSEPH P. CAIN.

Dr. Joseph Palmer Cain, of St. John's, Berkeley, S. C., died, in his 68th year, at the residence of his niece, Mrs. W. Huger Fitzsimons, Wednesday, Oct. 14th ult., after a short illness. He was a son of the Hon. William Cain, a Lieutenant Governor of the State under the old regime, and no South Carolinian in private life represented more thoroughly the ideals of the old South and was a finer "impersonation of high thoughts seated in a heart of courtesy."

Dr. Cain, after education at the best private schools, entered the South Carolina College, from which he was graduated in 1856, in the same class with Guido N. Lieber, afterward Judge Advocate General of the United States Army, and Charles Woodward Hutson, the literateur and educator, now of Texas. He received his professional education at the Medical College in this city. At the outbreak of the war Dr. Cain volunteered with his three brothers, he entering the Tenth Regiment as assistant surgeon. This post was not near enough to the battle line and he subsequently resigned it, serving with gallantry and efficiency as volunteer aide on the staff of Gen. A. M. Manigault through the bloody campaigns of the Army of Tennessee to the end of the war.

Returning to his ancestral acres in St. John's, Berkeley, he resumed the practice of medicine at Pinopolis, winning and holding the confidence and affection of all the people up to the day of his death.

Dr. Cain married Miss Mary, daughter of the late Hon. Charles Macbeth, who, with eleven children, survive him.

His remains were interred in Black Oak Cemetery, near Pinopolis, S. C.

### DR. B. G. DYSART.

Dr. B. G. Dysart, an ex-surgeon of Cockrell's brigade of the Confederate Army, died of pneumonia at his home in Paris, Mo., Jan. 17th inst., aged 70 years. He was a close friend of United States Senator Francis M. Cockrell. Many stories are told of the personal bravery of Surgeon Dysart during the Civil War.

**DR. JNO. A. HICKMAN.**

A brief note from his widow informs us of the death of Dr. John A. Hickman, of Cynthiana, Ky., who died at his residence Nov. 18th ult.

From his "Record Blank" on file the following facts are obtained:

Born in Spencer County, Ky., Nov. 30, 1827; entered the C. S. A. as surgeon Ninth Kentucky Infantry, subsequently serving as surgeon Sixth Kentucky Infantry at Chickamauga; was with McKown's division at the battle of Murfreesboro; had charge of the Dufford Building Hospital after the battle; was on hospital duty at Adairsville, Ga., part of 1864, and at Columbus, Ga., at the close of the war.

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***Editorial.***

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**MEDICAL DEPARTMENT OF THE UNIVERSITY OF THE SOUTH,  
SEWANEE MEDICAL COLLEGE, ANNUAL COM-  
MENCEMENT EXERCISES.**

THE commencement exercises of the medical department of the University of the South began on the evening of January 21, with the celebration of the anniversary of the John S. Cain Medical and Surgical Society, in the hall of the college, at Sewanee, Tenn. The President of the society, Arthur Frank Kyger, M.D., Ph.G., B.S., directed the exercises, which consisted of a historical review of the John S. Cain Society, then celebrating the tenth year of its existence, read by William Taylor Elmore, M.D., of Florida; an address upon "Medical Ethics," by Dr. John S. Cain, Dean of the medical department, for whom the society is named, and an address on "Necessity of Education in the Profession," by B. L. Wiggins, LL.D., Vice Chancellor of the University. After the close of the exercises, a reception and smoker was tendered the medical graduates in the rooms of the E. Q. B. Club.

Following are the graduates of the medical department: Joseph James Boston, of New York; J. L. Brennan, of Pa.; B. E. Britt, of Tenn.; W. G. Clopton, of N. Y.; R. G. Ducote, of La.; J. O. Duhon, of La.; W. T. Elmore, of Fla.; C. Espy, of Ala.; J. A. Fox, of W. Va.; C. J. French, of Va.; R. P. Griffith, of Va.; J. H. Hicks, of Tex.; J. C. Jett, of Va.; F. J. Kosek, of Pa.; A. F. Kyger, of Miss.; F. A. McCall, of Tex.; W. T. Moore, of N. C.; P. P. Nottingham, of W. Va.; D. W. O'Leary, of Ind.; E. A. Poret, of La.; E. B. Powers, of Va.; C. T. Rogers, of Va.; S. M. Stone, of Va.; J. R.



Sutton, of Va.; A. B. Sambola, of La.; John Tolson, of La.; J. W. Warren, of La. Of these Dr. Hicks received the medal for class honors in the medical class, and D. W. O'Leary that for similar honors in the pharmacy class. Dr. McCall and Dr. A. F. Kyger both made high grades in the practical branches of medicine and received honorable mention.

The commencement function was presided over by Vice Chancellor Wiggins. The diplomas were presented by the Dean, and the Vice Chancellor conferred the degrees of Medical Doctor and Graduate in Pharmacy by a dignified formula peculiar to the University of the South. Fred Alder McCall, M.D., was valedictorian of the class. The Dean, Dr. John S. Cain, delivered the charge to the graduating class, and in congratulating the university upon the wonderful growth and development of its medical department during the eleven years of its existence, announced that hereafter instead of having sessions lasting nine months as heretofore, the sessions of the medical department will open on April 3 and close in October. The other departments of the university open on March 17.

This school, located on the Cumberland Plateau, two thousand feet above sea level, in the quiet, healthy, and delightful university town of Sewanee, is conducted on the graded system, and in all respects in line and harmony with both of the College Associations of the country.

Up-to-date equipments, with superior laboratory and clinical facilities, enable it to offer excellent opportunities for study at this season of the year, in this favorably-situated locality.

\* For catalogue and special information address J. S. Cain, M.D., Dean, at Nashville, Tenn., until April 1, afterwards at Sewanee, Tenn.

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MASENGILL BROS., manufacturing pharmacists, of Bristol, Tenn., expect to put on some new traveling men during February to handle their line of pharmaceutical and physicians' supplies. Those desiring to make application for these positions should write them without delay.

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**BIOPLASM.**—In naming six animals of the polar regions a civil service applicant under examination wrote "six polar bears." In giving all the best remedies for disorder of the metabolic equilibrium, Bioplasm can be repeated *ad libitum*, for it is so eminently above any class, it stands alone and beyond comparative possibility. It may be said, also, that Bioplasm is *the* remedy for disturbed cellular function, although there are others more or less helpful. This is so true that the therapeutic action, in those cases where the sluggish disposal of waste proteids, is a matter for complaint. The rapid cell osmosis which is stimulated by Bioplasm in such cases, throws into the blood-stream an unusual mass



of end-products, all toxins in varying degrees, uric acid being the final one and the least toxic. If the gross excretory organs should fail to keep up with the blood demand for relief, the result would be, or might be, what may be properly named "physiological toxemia," tentative and symptomatic and harmless, but with some subjective indications. Wherever Bioplasm does appear to be negative in result, this is the solution as rare exceptions as are the negative cases. The indications are self-evident—stimulation of excretion—especially of the kidneys and bowels—by using Sal Lithia.

### PRICES OF ANTITOXIN.

QUITE a stir has been raised in the past few weeks, emanating from Chicago, in regard to an advance in the prices of Antitoxin Serum, the newspapers of the "Windy City" with "scare-head" headlines characterizing the manufacturers of Biological products as the "Death Trust!"

The following correspondence is respectfully placed before our readers with the statement that in no single instance have we been disappointed using any of the products of the magnificent and thoroughly equipped laboratories of Messrs. Parke Davis & Co.:

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

103 DEARBORN AVE., CHICAGO, Jan. 15, 1904.

Messrs. Parke, Davis & Co., Detroit, Mich.

*Gentlemen:* There has been a good deal of comment in the newspapers in reference to the alleged combination of the antitoxin manufacturers, with a consequent rise in price, which it is claimed is fifty per cent over former prices. How much truth is there in this statement? Kindly let me have your side, as we have been requested to take up the matter. Also, will you kindly send me your price list in force three months ago or more and that of to-day, both wholesale and retail. Thanking you in advance for the favor of a reply, I am

Respectfully yours,

GEORGE A. SIMMONS, *Editor*.

January 16, 1904.

George H. Simmons, M.D., Editor of the Journal of the American Medical Association, 103 Dearborn Avenue, Chicago, Ill.

*Dear Sir:* In answer to your inquiry of the 15th we have pleasure in making the following statement: Beginning January 1, 1904, we market only one grade of antitoxin, in four packages or doses:

Number of Units.	List Price.
1,000.....	\$2 00
2,000.....	3 50
3,000.....	5 00
4,000.....	6 50

Trade Discounts: 25 per cent to the retail, and 33 1-3 per cent to the wholesale druggist

**Injecting Device:** With each package of the "new serum" we now supply an expensive device for administering the contents, sparing the physician the need of buying and sterilizing a serum syringe.

**Last Year's Prices:** Last year we marketed *two* grades of Antidiphtheritic Serum—the Standard or X serum, testing 200 and more units to the Cc., the more powerful and concentrated Special or XX, testing 500 and more units to the Cc., at the following prices:

Number of Units.	X Prices.	XX Prices.
1,000.....	\$1 50	\$2 25
2,000.....	3 00	4 00
3,000.....	4 50	5 75
4,000.....	Not formerly listed.	

**Last Year's Discounts:** Only 20 per cent to the retailer; to the wholesaler, 33 1-3 per cent.

**Injecting Device:** None furnished until the close of the year.

**Potency of the New Serum:** In the 4,000-unit package we are placing serum testing on an average of 600 units to the Cc.; in the 3,000-unit package, serum testing on an average 500 units to the Cc.; in the 2,000-unit package, serum testing on an average 400 units to the Cc.; and in the 1,000-unit package, serum testing on an average 300 units to the Cc.

Thus, comparing prices and discounts, old and new, allowing for the additional cost of the injecting device, and remembering that the new serum, in point of concentration and antitoxic potency, is much superior to the X and all but equal to the XX, you will see that our 1904 prices *exhibit a reduction and not an advance.*

**Free Exchanges:** *Fully forty per cent of all the serum we sell comes back for free exchange.* What becomes of the returned serum? *It is poured into the sewer.* This is the sole reason for our marketing, henceforth, one grade of antitoxin in place of two, and *four* packages or doses in place of ten. The producer, the retailer, and the wholesaler will be spared a useless trouble and an enormous expense, while the physician *loses nothing* thereby.

**The Chicago Department of Health:** For years the department profited by the illegal and unconstitutional action of the New York Board of Health, which sold to Chicago its surplus serum. When Mayor Low and Dr. Lederle discontinued such sale, the department, by playing off one producer against another, succeeded in screwing down the price until its business was altogether unprofitable. We *know* that every sale of serum *ever* made the Chicago department by a private producer has been made at a loss. We see no reason why, in buying antitoxin for its poor, the great city of Chicago should compel us to furnish our product at a loss. How much money will Chicago have to spend for antitoxin to be donated to its poor? Less than \$5,000 a year. If a single life is sacrificed among the indigent sick of your city, it will be solely because the

department refuses to pay a fair and reasonable price for a good product. *As for the diphtheria sufferers who are not charity patients, they will henceforth pay less and not more, quality considered.*

**Federal Supervision:** A Federal law compels all makers of biological products to work under Federal license and supervision, the license being revocable for faulty equipment of men or appliances, or unsatisfactory product.

Considering the harassing dangers and responsibilities of our biological work, our immense investment of capital, our employment of the most expert scientific talent, and the heavy waste in the form of free exchanges, we feel wholly warranted in writing and urging you to send to Detroit at our expense a trusty and accomplished biologist. Let him come, see our laboratories, compute our expenses and producing costs, and publish his report in your pages. We are prepared to stand or fall by the verdict of any unbiased expert or commission.

Very truly yours,

PARKE, DAVIS & Co.

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#### GLYCO-THYMOLINE IN PHTHISIS AND TUBERCULAR INVASION OF THE SUBMAXILLARY AND CERVICAL GLANDS.

It seems to have been thoroughly established that in most cases tubercular infection has been through the mouth and naso-pharynx. This being the case, a protection of these parts from invasion is of the first consequence. In a recent note on this subject Prof. Arnulphy, of Paris, says that in addition to other methods to protect those persons as physicians, relatives, nurses, etc., who are compelled to come in contact with consumptive patients, the frequent daily use of Glyco-Thymoline as a mouth, throat, and nasal wash will insure a degree of immunity from infection that reduces the danger to a minimum. To those already suffering from the disease, Glyco-Thymoline has proved of great value as a means of keeping the mouth, nose, and cervical glands in an aseptic condition with a marked alleviation of cough and irritation. The action of the solution of Glyco-Thymoline on the mucous membranes is soothing and distinctly exosmotic, increasing the capillary circulation.—*New York Medical Journal, January 9, 1904.*

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Is it not true that nine-tenths of the cases of illness coming under the care of a physician are characterized by fever and pain? Is it therefore not obvious that much of the success that comes to medical men is owing to the more or less prompt relief given to these conditions? From this standpoint Febrisol Liquid (Tilden's) should command the special respect of the medical profession as a certain means of making friends, money, and reputation. Febrisol Liquid accomplishes these results because of its antipyretic, antiphlogistic, and analgesic action, which is

unattended with depressant effects. And most important to observe, it causes no drug habit, and does not, like opium, wreck the patient's mind while he is made oblivious of pain. Febrisol Liquid relieves the pain by reducing the inflammation, which is the cause thereof. It sets the circulation at rest by calming the nerve centers in the medulla, and through its influence upon the vaso-motor nerves it opens the flood gates of the skin, producing gentle perspiration, and thus cools the blood.

Experience amply shows that there is no more safe, efficient, thoroughly reliable remedy in such conditions than Febrisol Liquid (Tilden's).

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**COUGH AND RESTLESSNESS IN PNEUMONIA.**—Dr. W. J. Parker truthfully states in the January *Medical World* that "the season for pneumonia is here," and it may be of interest to our readers to know that he has found an excellent remedy for the cough and restlessness which are such distressing symptoms of this dreadful malady in antikamnia and heroin tablets. Each of these tablets contain five grains of antikamnia and one-twelfth grain heroin hydrochloride, and the dosage is one tablet every two or three hours according to the exigencies of the case, or at the discretion of the attending physician. We may also add that Prof. Uriel S. Boone, of the College of Physicians and Surgeons, St. Louis, also reports most satisfactorily results with this remedy in pneumonia, bronchitis, and la grippe, particularly in relieving the accompanying spasmodic coughs and muscular pain.

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#### **TYREE'S ANTISEPTIC VERSUS BICHLORIDE, CARBOLIC, ETC.**

NONE of the objections to corrosive sublimate, carbolic acid, and other agents of this class—namely, toxicity, chemical union with albumin, superficial effect only, change to inert compounds, corrosive action upon tissues, harm to metal instruments, injury to the hands, etc.—prominent in medical literature are experienced in the use of Tyree's Antiseptic Powder.

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"MANY a man is to-day worrying over a case or two of pneumonia, pleurisy, or capillary bronchitis, whose troubles would flit away like mist did he but know enough to put his patient into a jacket of anti-phlogistine."—*Medical Summary*, November, 1902.

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#### **CHRONIC CYSTITIS.**

S. C. SMITH, M.D., Henderson, Ky., says: "I am much pleased and somewhat surprised at the remarkably good effect Satyria is having in a female patient with chronic cystitis and incontinence of urine."

**TWO GOOD ONES.**—For the past twenty-five years the Tongaline Preparations have been regarded by the medical profession as the standard remedy for rheumatism, neuralgia, grip, nervous headache, gout, sciatica, lumbago, etc., which of itself is the strongest testimonial to their wonderful intrinsic merits.

Ponca Compound, a uterine alterative, relieves congestions, encourages peristalsis, removes spasmodic conditions, and regulates the vascular supply, being invaluable in all uterine and ovarian functional troubles.

---

I HAVE used more or less of the two elegant preparations, Peacock's Bromides and Chionia, during the last two or three years, and must say with very satisfactory results.

B. A. BOBB, M.D.

Mitchell, S. D.

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I HAVE used Seng and Cactina Pillets in my practice and find that they are all that has been claimed for them. Seng is excellent in those forms of indigestion following chronic catarrh of the stomach and bowels. I like the effect of Cactina Pillets in weak heart. I have used it for the last seven years.

A. M. ARMSTRONG, M.D.

Crawford, Tex.

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## *Selections.*

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**SUPPURATING APPENDICITIS OPENING INTO THE BLADDER.**—Juan G., a Spanish merchant, 37 years old, with evident syphilitic antecedents, began to suffer about two months ago acute pains in the right iliac pit, while a tumefaction was observed in that region.

He became an inmate of a clinic of this city, where his case was diagnosed as malignant neoplasm. After remaining about twenty days in said clinic, the patient decided to leave for Spain; in the meantime, he stopped at a hotel here. While there he was taken with violent fever and ague, with a temperature of about 41 degrees C., and the first micturition following this attack did show the presence of a great quantity of pus.

Dr. Parra, who was attending the patient, did me the honor to ask me to assist him. I called on him the night after the evacuation of pus had occurred.

The first symptom to which my attention was called upon examination was the dimension and hardness of the liver, with

swellings, the massiveness of which continued uninterruptedly in connection with the massiveness of the iliac pit, in which region (the right iliac pit) an accentuated muscular resistance was observed, though that region instead of being swollen presented a depression, at the bottom of which the rim of the hepatic gland could be felt by the hand. The temperature was 38 degrees, the pulse beat between 80 and 90, and the general condition of the patient was rather satisfactory.

The diagnosis offered no doubt in our opinion: Suppurating appendicitis with evacuation into the bladder (the urine which was shown to us was extremely fetid and mingled, and it did contain a large quantity of pus) and syphilitic cirrhosis of the liver.

We advised the patient to consent to be operated upon, which he did. On the following day an incision of about seven centimetres was made into the middle of the depression observed in the iliac pit. We rapidly reached a perfectly defined cavity, which contained a little pus mixed with mucosities. We washed out the cavity with hydrozone and plugged it with iodoform gauze. On the following day when we dressed the wound, upon careful examination of the cavity, we did not find any connection with the bladder, but we could extract the appendix, which was affected by faeces.

A complete cure was accomplished in a month, and during that time the liver decreased considerably in volume. Since the third day of the operation anti-syphilitic treatment was followed.

The communication between the cavity of the abscess and the bladder healed after twelve days of treatment.—Dr. Enrique Fortun in *Revista Medica Cubana*, July, 1903.

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CHILBLAINS to many will appear a trifling matter, but as one whose school days in winter were rendered miserable by them, I can assert that they are most maddening. Last winter my daughter, aged 11, suffered from them severely. Each time antiphlogistine was applied, the redness and intolerable itching disappeared in a night. I have tried remedies innumerable with no such result.

**Pleurisy:**—Dr. Colin Campbell, Southport, Eng., L. C. R. P., M. C. R. S., writes in the *Medical Press and Circular*, London, Eng., Oct. 7, 1903:

Dr. B. was under my care last winter, suffering from a pulmonary cavity. He had had previously two or three intercurrent attacks of pleurisy, which I again found present on Dec. 7, 1902, accompanied by severe pain over the cavity, and a temperature of 103 degrees. His previous attacks had occurred at his home, where careful poulticing was practicable, but in apartments this was unsatisfactory, and so it occurred to me to try antiphlogistine.

The material was warmed and "troweled" on for many inches around the pleuritic center, then covered with non-absorbent lint and Jaconet.

The result was remarkable; the pain disappeared within an hour, and the high temperature within two days.

Many advantages over poulticing were noticed by the patient; facility of application, no unendurable heat, rapid relief from pain, its adhesiveness rendered movement possible without tight bandaging or the alternative sudden influx of cold air which follows the separation of a poultice from the skin.

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**DEPRESSANT DRUGS AND SUDDEN DEATHS.**—It is very interesting to examine the statistics of sudden death from heart disease in New York City during the last three years. In 1900 there were registered 4,069 deaths from heart disease in the Greater City of New York in a population of approximately 3,445,000, while in 1901 there were 4,626 such deaths, the population having presumably increased about 100,000. Thus there was an increased ratio of sudden deaths to population. In 1902 the number of sudden deaths reported from heart disease had increased still further to 5,461. Calculating the percentages of sudden deaths from heart disease to population, allowing for the before-mentioned increase of population, the deaths of this kind to each thousand were, in 1900, 1.18; in 1901, 1.31; in 1902, 1.34.

For the year 1903 there was a decrease in the number of deaths from this cause, so that the ratio was only 1.28 per thousand. There has been some discussion among sanitarians and public-health officials as to the reason for this decrease.



A portion of the decrease has been ascribed definitely—and with considerable plausibility—to a certain cause. At the beginning of last year the Board of Health, suspecting that many prescriptions for phenacetin were being filled by druggists with acetanilid, or with a mixture of phenacetin and acetanilid, sent inspectors to obtain definite information on this matter. Altogether 373 samples of phenacetin were bought from the same number of drug stores in various parts of the city, phenacetin being specially asked for and in some instances even obtained, on a physician's prescription. Of the 373 samples, 58 were pure phenacetin, 315 were adulterated with cheaper drugs, mainly acetanilid, and in 267 cases containing more acetanilid than phenacetin; 32 samples were pure acetanilid. The commissioner made these facts public, and threatened to expose and prosecute all druggists who would hereafter be found committing this misdemeanor.

It is very interesting at least to find that a single year after the investigation and supposed consequent reform on the part of the dispensing pharmacists, there should be a slight reduction in the actual sudden death rate from heart disease, and that at a time when for many years there has been a constant increase in the death rate from this cause. It is well known that acetanilid is a distinctly depressant drug for the heart. Prof. Jacobi, of New York, always insists that it is an actual tissue poison, to be used only with great care, and many therapeutists teaching that it is the underlying cause for the increase in reported sudden deaths that has occurred in recent years.

This question of the evil of depressant drugs is all the more interesting because of the freedom with which so-called headache powders, mainly composed of acetanilid and other heart-depressants, are now so commonly bought and sold. Many women, and even men, think nothing of stepping into a drug store and asking for something for a headache. The headache powders that are dispensed to them so freely always contain acetanilid, and great harm is being done in this way. It is probable that a similar investigation in other cities of the country might also furnish instructive facts. Certain it is that proper legal regulation of the sale of such depressant drugs, so that they could not be dispensed except under the direction of a competent physician, would in the long run have a beneficial effect on the sudden death rate from heart disease.

This cause of sudden death is becoming more frequent in this country, and is a serious menace for those suffering from even slight forms of heart disease if they are so foolish as to take these remedies.—Journal of American Medical Association.

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**TREATMENT OF ABSCESSSES WITH NITRIC ACID.**—M. Porosz, of Budapest, exclaims that if any one has once used a 2 to 5 per cent. solution of nitric acid in treatment of abscesses and buboes he will never treat them in any other way, as the effects are so satisfactory. He first evacuates the pus and then injects the solution with a urethral syringe as forcibly as possible. The abscess cavity becomes distended with the fluid which penetrates into every crevice and seems to stimulate the tissues in their work of repair after the germs in the lesion are killed by the action of the acid. In very deep buboes it may be necessary to repeat the injection daily, but healing is usually complete after two injections. The severest cases all healed in a week in his experience.—Klinisch-therap. Wochft., X., No. 33, 1903.

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**THERAPY OF IRON.**—After studying a large number of cases, including the various forms of anemia and estimating the amount of hemoglobin and the number of corpuscles, Bier-nacki, in International Medical Magazine, concludes that only in chlorosis is the administration of iron of real value. In other forms of anemia nothing can be expected from its use. He states, particularly, that the large number of neuropathic individuals, though pale and having the symptoms of anemia, show no real impoverishment of the blood and are injured rather than benefited by iron medication. Consequently he condemns the widespread custom of prescribing iron in cases of pallor without a proper examination of the blood. When indicated, as in chlorosis, iron should be given in large doses. No benefit can be expected from the use of chalybeate waters.—Journal of American Medical Association.

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**CHRONIC NEPHRITIS WITHOUT ALBUMINURIA** (Elliot, *Medical News*, September 19, 1903).—With a report of several cases, Elliott concludes as follows: "1. Latency of symptoms is so constant

a characteristic of chronic interstitial nephritis as to almost constitute its most salient feature. This obscurity involves all manifestations (symptomatic, physical, and urinary) and prevails throughout the entire course of the disease. 2. Latency of symptoms does not constitute a point of absolute distinction between the early and the advanced stages, or between the mild and severe forms of the malady.. 3. Symptoms are especially liable to be absent, and urinary signs uncertain during the early stages of chronic interstitial nephritis, consequently the diagnosis during this period must generally be made from physical signs rather than from symptoms or urinary signs. 4. Albumin is absent from the urine of this form of nephritis with great frequency. It may frequently be absent during the early stages. It may occasionally be absent until the disease enters the final stages. It may rarely remain absent from the urine throughout the entire course of the disease, the urine remaining free from albumin so long as no intercurrent disturbance apart from the nephritis arises to cause it to appear. Albuminuria, therefore, constitutes a very unreliable diagnostic sign in this disease. When present, associated with physical signs and other urinary indications, it serves to complete the diagnosis; but if absent, no contrary inference is justifiable, and the diagnosis must be considered without its aid. 5. More reliable evidence of renal change is a diminution in the gross amount of urinary solids, and especially significant is the presence of casts. 6. Chronic interstitial nephritis never exists as a clinically recognizable condition without the presence of casts in the urine. Although a renal diagnosis cannot be founded on casts alone, they constitute a corroborative sign of high clinical value, when associated with other indications. 7. The secondary circulatory changes following chronic interstitial nephritis are so constant and characteristic as to furnish, in most cases, sufficient ground for the recognition of the disease before reference is made to the urine. The inconstancy of the urinary symptoms places them in much the same diagnostic category in chronic interstitial nephritis as that occupied by the murmur in valvular diseases of the heart. The diagnosis should be made, if possible, from the physical signs and symptoms, the urinary indications being regarded as corroborative rather than as essential evidence."—*Medical News*.

**HYPERIDROSIS OF THE FEET TREATED BY FORMALIN.**—From observations made on soldiers in the French army, Vaillard reports favorably upon the results of formalin treatment for excessive sweating of the plantar surface of the feet. The effects of formalin are to deodorize the perspiration when it is fetid; to harden the epidermis, thereby avoiding the consequences of maceration; to diminish or totally suppress the glandular secretion by its action upon the epithelium; and finally to heal the excoriations by its local antiseptic action.

The strength of solution employed varies from the commercial formaldehyde (40 per cent. formalin) to 2.5 per cent., according to the nature of the case. If there is much maceration and excoriation of the skin, the weakest dilution should be applied at first, and then rapidly increased in strength.

The method of application is to bandage wet compresses to the soles of the feet three or four times every twenty-four hours, care being taken to protect the interdigital surface, since here formalin causes great pain and often excoriation. The period during which the applications are made necessarily varies from twenty-four hours to eight days, according to the strength of the solution used. In those cases in which pure formaldehyde can be used the cure is almost immediate. The benefits derived from the treatment are only temporary, lasting from a few weeks to three months, but are quickly renewed by a repetition of the applications.—*American Journal of Dermatology*, November, 1903.

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**INJECTIONS OF CAMPHORATED OIL IN PULMONARY TUBERCULOSIS.**—E. Nienhaus treated seventeen patients with subcutaneous injections of camphorated oil after the method of Alexander. The injections were given either daily (0.3 g. of ten per cent camphorated oil), or 0.1 g. of camphor was given daily for four days, then an intermission of eight days, four days of treatment, etc. It was found that the injections were well borne and never produced any disturbances of the general condition. Its action, however, is merely that of a heart stimulant, and it has no direct effect on the local pulmonary condition. The blood pressure is not raised by the treatment, neither is the temperature influenced. The injections are of value in strengthening a heart severely poisoned by advanced disease, and in this way prolonging life, though large doses must be used. Hemorrhage is a contraindication.—*Zeitschrift für Tuberkulose und Heilstättenwesen*, Vol. V., No. 1.

TREATMENT OF SURGICAL SHOCK BY ADRENALIN.—E. Martin and M. E. Pennington report five cases in which this drug was used in *American Medicine*. In two of these cases the effect of the adrenalin was immediate and unmistakable; in both it seemed life-saving. But the clinical evidence produced as to its effect must be regarded as inconclusive on all points. It was not employed on a single patient in which there was a fair prospect of the preservation of life without its use; hence the unbroken mortality of this series of cases cannot be counted against it. One case of typhoid perforation apparently speaks strongly in its favor. This one case, however, must be corroborated by many others before confidence may be placed in the drug. Laboratory experiments apparently show that adrenalin by intravenous injection is the most powerful, practicable cardiac and vasomotor stimulant yet presented to the profession. Its value is still further enhanced by the fact that it stimulates the respiratory center and increases general metabolism and body temperature. The toxic dose for man is not known, but is probably several hundred times greater than that in which the drug is ordinarily given. Because of the rapidity with which it undergoes alteration in the body, it is inert in so far as its systemic effect is concerned when given either by the mouth or by the rectum. Because of the tendency to abscess formation at the seat of injection incident to the ischemia caused by a strong solution, the dilution should be at least 1-10,000 when the drug is given hypodermically. Nor does it seem probable that any effect can be expected, when thus administered, from less than 2 cc. of the 1-1,000 solution. Apparently, it is safe to give an initial dose of 10 cc. of the strong solution in 90 cc. of normal salt. In cases of urgency adrenalin chloride should be given intravenously in a dilution of 1-10,000. The injection should be slow, thus prolonging the effect of the drug, and should be pushed up to 100 cc. of the strong solution or until the heart clearly and unmistakably responds to its influence. There is as yet no convincing clinical proof to the effect that the drug is as efficacious when used on man as laboratory experiments would lead us to suppose. Because of its power of lessening the bacteriolytic power of the blood of animals, its use in cases of infection in the human should be practiced with great caution until a wider experience has proved its safety or danger in these cases. Clinical evidence strongly suggests that it exerts a similar power upon the blood of man.—*St. Louis Medical Review*.

# Listerine

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Listerine is a well-proven antiseptic agent—an antizymotic—especially useful in the management of catarrhal conditions of the mucous membrane, adapted to internal use, and to make and maintain surgically clean—aseptic—all parts of the human body, whether by spray, injection, irrigation, atomization, inhalation, or simple local application.

Listerine is a swift and sure destroyer of infusorial life; it prevents the various fermentations, preserves animal tissues and inhibits the activity, growth and motion of low forms of vegetable life: hence Listerine may be relied upon to destroy the activity of the living particles which constitute contagion whenever brought into intimate contact therewith.

**For diseases of the uric acid diathesis:**

## Lambert's Lithiated Hydrangea

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*Adrenalin Chlorid in Nasal Disturbances.*—Adrenalin chlorid applied in the form of a spray or on pledgets of cotton, or in some cases dropped in with a medicine dropper, has been used extensively and to good advantage in nasal disturbance by S. G. Dobney,, according to an abstract in Medical Review of Reviews. He has found it to be of great value in the treatment of hay fever, and other nasal neuroses producing transient obstruction due to swelling of the turbinates. Good results also followed its use in acute rhinitis, thereby shortening the attack. It is superior to cocain, according to the author, in making a diagnosis between general hypertrophy of the nasal mucous membrane and a turgescence of the erectile tissues; in nasal operations, especially on the septum, its ability to check the hemorrhage is marvelous; however, in epistaxis it is of but little avail except when it consists of gentle oozing. He employs the following combination in the treatment of the foregoing conditions:

R. Sol. adrenalin chloridi (1-100).....oz. i  
Resorcini  
Sodii chloridi, aa.....gr v  
Aquae destil.....oz i

M. Sig.: To be used locally in the form of a spray or on pledgets of cotton.



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In therapeutic qualities and physical characteristics, GLYCO-HEROIN-(SMITH) presents the highest progress of Medicine in the treatment of these diseases.

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The adult dose of GLYCO-HEROIN-(SMITH) is one teaspoonful, repeated every two hours or at longer intervals as the case may require.

Children of ten or more years, from a quarter to a half teaspoonful.

Children of three years or more, five to ten drops.

Sample and literature  
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**NAPHEY & CO.** - - - - **Warren, Pa.**

Beaman Douglas recommends the following combination to be used in diseases of the nose and throat and for operative purposes:

R. Cocainae hydrochlor .....gr. v  
 Sodii chloridi .....gr. x  
 Beta eucaine .....gr v  
 Ext. adrenalis ex sic.....gr. xxx  
 Aquae .....oz. i

Misce. Add the water to the dried suprarenal gland, filter and add the eucain and sodium chlorid and finally the cocain just before using. Sig.: Six minims to be injected beneath the membranes or applied locally on membranes by means of an applicator.

*Acute Eczema.* — In the treatment of acute eczema, according to Bjorkman in Merck's Archives, if it is localized, a moist dressing should be applied containing 2 per cent. of boric acid or a dressing saturated with a solution of aluminum acetate (1-10).

If the eczema covers larger areas a dusting powder is of value, as follows:

R. Zinci oxidi  
 Pulv. amyli, aa.....dr iiss  
 Talci venet.....dr vi  
 M. Ft. pulvis. Sig.: To be used locally several times a day.

As a salve in these forms of acute eczema the following is of service:

R. Bismuthi subnit.....dr. i  
 Lanolini .....dr. ii  
 Liq. petrolati q. s. ad.....oz. ii  
 M. Ft. unguentum. Sig.: Apply locally; or:

# Bronchiline

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A valuable remedy in the treatment of all irritable conditions of the respiratory tract. Efficient and agreeable. Contains no Morphine, Heroin, nor any form of opiates ; gives prompt relief. Has been endorsed by leading physicians all over the United States for fifteen years, Formula furnished upon application. Prepared in 16-oz. bottle. Prescription price \$1.00. A full-sized bottle sent to any physician, prepaid, upon receipt of 50 cents in stamps, to cover expressage.

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**NEAT-RICHARDSON DRUG CO. LOUISVILLE,  
KY.**

## PRESCRIPTIONS AND FORMULARY.

R. Acidi salicylici .....gr. x

Zinci oxidi

Amyli, aa.....dr. iiss

Liq. petrolati q. s. ad.....oz. i

M. Ft. unguentum. Sig.: Apply locally.

If the pruritus is pronounced the following lotion containing carbolic acid will be of assistance in checking the itching:

R. Acidi carbol.....gr. xx-xxv

Aqua rosae

Aquae destil, aa, ad.....oz. iii

M. Ft. lotio. Sig.: To be externally applied; or as a salve, the following to relieve the pruritus:

R. Acidi salicylici .....gr. vi

Menthol .....gr. xi

Olei lini

Aq. calcis, aa, ad.....oz. ii

M. Sig.: To be applied locally.

Another very effective combination is:

R. Ichthyol.

Zinci oxidi, aa.....dr. i

Lanolini .....dr. iii

Liq. petrolati ad.....oz. i

M. Ft. unguentum. Sig.: Apply locally.

*Erysipleeas*.—In Medical Review of Reviews Smolitcheff states that erysipelas can be treated locally with success by employing a remedy which is readily absorbed by the skin, and which is powerful enough to kill the active organism, the streptococcus, or at best to prevent its further activity. The remedy must, at the same time, when taken up by the circulation, neutralize existing toxins and fortify the cells against their invasion and producing at the same time a leucocytosis. To fulfill such requirements he recommends the alcoholic tincture of iodine as a specific comparable to the effects of quinine in malaria. This preparation diminishes the swelling and pain and causes a drop in the temperature. The following combination is recommended by the author:

R. Tinct. iodi .....dr. vi

Olei camphorae

Ichthyol, aa.....dr. iii

M. Sig.: Shake and apply locally twice or three times a day.



## PRESCRIPTIONS AND FORMULARY.

*Glycerinate of Tannin in Burns*.—According to an abstract in Medical News the glycerinate of tannin has been found to be a most satisfactory preparation in the local treatment of burns. If the burns are of the second degree the vesicles should be punctured and the fluids removed, after which glycerin and tannin should be applied in 50 per cent. solution and covered by sterilized gauze and cotton. The solution should be applied several times a day without changing the gauze. Burns of third degree should be treated likewise. The good results are ascribed to the effects of the tannin on the diseased tissue, coagulating the albuminous substances and forming a protective coating, also the glycerin is an antiseptic.

*Otitis Mediar*.—Patients suffering from acute otitis media must be kept indoors, according to Kansas City Medical Record, and given a purgative. Every two hours the temporal and mastoid regions and the ear should be covered with a compress dipped in a solution of sodium bicarbonate (60 parts to a 1,000) as hot as can be borne by the back of the hand. The whole may then be covered by a piece of oiled silk and held in place by a bandage. Previous to applying the compress three or four drops of the following solution may be dropped into the ear:

R. Cocainae hydrochlor .....gr. iss  
Resorcini .....gr. xij  
Glycerini (neutral, sterilized).....dr. iiss

M. Sig.: Three or four drops instilled into the ear at every second dressing. Three or four times during the day the child should be placed on the bed with the head low and a few drops of the following combination instilled into each nostril:

R. Menthol .....gr. iv  
Olei amygdalae dulcis .....oz. i

M. Sig.: To be introduced into the nares by means of a medicine dropper three times daily.

The mouth and pharynx should be thoroughly cleansed and irrigated three or four times daily with boiled water and introduced with a fountain syringe. If the pain does not cease within a day or two and the tympanum becomes bulged and red, paracentesis should be performed.

To serve as an astringent, the following is recommended by the author:

# SANMETTO FOR GENITO-URINARY DISEASES.

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A Vitalizing Tonic to the Reproductive System.

SPECIALLY VALUABLE IN  
PROSTATIC TROUBLES OF OLD MEN—IRRITABLE BLADDER—  
CYSTITIS—URETHRITIS—PRE-SENILITY.

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## PRESCRIPTIONS AND FORMULARY.

R. Acetanilidi  
 Bismuthi subnit, aa.....gr. xxiiss  
 Ung. zinci oxidi  
 Ung. aq. rosae, aa, ad.....oz. i

M. Ft. unguentum. Sig.: Apply locally; or:

R. Alumnol .....gr. xxiiss  
 Ung. aq. rosae ad.....oz i

M. Sig.: Apply locally.

Gerhard recommends the following in relieving the pain in acute otitis:

R. Tinct. aconiti rad.....dr. iss  
 Glycerini (sterile).....dr. iiss

M. To be warmed and two or three drops instilled into the ear.

The following combination is also employed in relieving ear-ache:

R. Ichthyol .....m. xv  
 Glycerini  
 Aqua, aa.....dr. ii

M. Sig.: Warm and drop a few drops into the ear three times a day.

Hypophosphites in the Treatment of Abscesses:—Sinclair Tousey, in *Annals of Gyn. and Ped.*, recommends the employment of hypophosphite of calcium, sodium and potassium in the prevention and treatment of abscess formations. He recommends it in that class in which there is no evidence of virulent infection, but simply a swelling of the subcutaneous tissue presenting well-marked fluctuation without redness or pain, such as may occur in the axillae, perineum or about the neck. In the treatment of such conditions he recommends the following combination as being the most effective one:

R. Calcii hypophos.....gr. v  
 Sodii hypophos.....gr. ii  
 Potass. hypophos.....gr. ii

M. Ft. capsula No. i. Sig.: One such three times a day.

If preferable the foregoing may be taken in the form of a syrup. This combination is preferable to those containing iron or strychnia.

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## THE SOUTHERN PRACTITIONER

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### *Original Communications.*

#### MEMORIAL ADDRESS ON DR. W. E. B. DAVIS.\*

BY RICHARD DOUGLAS, M.D., OF NASHVILLE.

Mr. President and Fellows.—Let surgery pause and medicine slumber, for this hour is consecrated to the memory of one we all loved. This is the annual meeting of the Southern Surgical and Gynecological Association, yet Elias Davis is not among us. How strange it all seems! Who has not missed his cordial greeting so unmistakably sincere? Who does not look for that tall, awkward form, those clear cut angular features, those restless, penetrating but kindly eyes? Just a year ago, it seems but yesterday, he was with us, zealous and active as of yore; yet there was something on his face that bore the shadow of impending fate. Ruthlessly he was taken from us. Mourn him we must, forget him we cannot.

\*Read at meeting of Southern Surgical and Gynecological Assoc., Dec. 15, 1903.

Since last we assembled, three ex-Presidents of this association have crossed into the "beyond." Grim Charon only rests upon his oars a little while ere he calls for another passenger. Quickly, almost suddenly, the summons came to Dr. Engleman. Why should his like be taken from us; so gentle, cultured, loving and lovable. The flowers o'er his new-made grave have scarce lost their fragrance. Sweet memories of him will linger with us always. Next to follow was J. McFadden Gaston, the "Nestor" of Southern surgery; a veteran of almost four score years; a rugged, original character, always a thinker and leader of men. His honorable and varied career came to a peaceful end Nov. 15, 1903. Younger than either of these was Dr. Davis. Willingly but sadly, I will review his brilliant young life; not to glorify it, nor yet to indulge in soulless persiflage, but that those of us who lived with him and after him may be inspired by his nobility, impressed by his humanity and imbued by his ambition.

In the quiet village of Trussville, Jefferson County, Alabama, on Nov. 25, 1863, William Elias Brownlee Davis was born. He sprang from a line of physicians; his paternal ancestors for five generations were reputable practitioners of medicine; his father, a surgeon in the Confederacy, was killed at St. Petersburg, Virginia, leaving a widow and two sons impoverished by devastating war. Bereft of a father's guidance and support, these brothers Davis became the sole charge of their mother. Heroically she battled against adversity and instilled into these lads her gentle Christian spirit, and inspired them with their father's ambition and patriotism. From his earliest days, Elias Davis knew what it was to work. Upon the farm he did his quota to contribute to the family support. Being of a studious and active mind, every sacrifice was made by his mother and elder brother to give him the advantages of an education. His early training was in Trussville; later we find him a student in the University of Alabama, zealous in his work, but from ill health and for want of sufficient means he was unable to complete his college course. He entered upon the study of medicine under the direction of his brother, Dr. J. D. S. Davis, and later pursued his studies in Nashville and Louisville, finally graduating from the Bellevue Hospital College in 1884. Impatient to engage in active and productive life, he formed a partnership with his brother and entered upon the practice of his profession in Birmingham, Alabama.

Thus was initiated a career marvelous in its brilliancy, glorious in its achievements and unutterably sad in its sudden ending. As a lightning bolt from out the clear sky came the terrible accident which ushered into eternity the noble spirit of Dr. Davis. And what was left? A young and desolate widow engulfed in the despair of this horrible calamity; a broken-hearted brother bereft of the strong, sustaining influence and tender affection which welded their two lives as one; and two lovely little girls, not yet old enough to realize the magnitude of their misfortune. Nor was this all; a terrible gloom fell over all our Southland—the theater of his achievements. Thousands of hearts throbbed in sorrow. Nor yet, indeed, was this all. We, the Fellows of this Association, had lost our founder, our leader, our friend, and claim the sad privilege of mingling our tears with those nearest in blood.

Shrouded in the gloom of this bereavement is there no hope, no consolation? Imperishable in the ashes of this magnificent ruin, lie resplendent the jewels of virtue, honor, humanity and success. These adorn the crown of his career and in their refulgent rays we find comfort and encouragement. If to be honored by his fellowman was a part of the ambition of Elias Davis, then he attained the fruition of his wildest dreams.

Mark you how success attended every undertaknig. He has been active in the medical councils of his State and the Nation for fifteen years. As early as 1891 we find him succeeding Robert Battey as President of the Tri-State Medical Association of Alabama, Georgia and Tennessee. In 1893 he was Chairman of the Surgical Section on Abdominal Surgery and Gynecology in the first Pan-American Medical Congress, and Vice President of the second Congress. In 1900 we find him elevated to the Presidency of the American Association of Obstetricians and Gynecologists—an exalted position attained in a body where merit alone prevails. Some idea of the scope of his reputation is suggested by the fact that he was Honorary Fellow of the State societies of New York, Louisiana and of the British Gynecological Society. Alabama, a pioneer in educational requirements for license to practice, placed him upon her State Board of Medical Examiners. These were all notable honors; but the last and greatest of all came to him in 1901, when he was chosen President of this distinguished body. A man so conspicuously and constantly in the foreground of his profession must possess unusual traits of char-

acter, transcendent elements of success. These honors may occasionally fall by accidents of circumstance or political trickery upon the unworthy, but the profession does not reaffirm its judgment except upon the basis of merit. Individualizing the elements in the character of Dr. Davis, we find sufficient reason for his ascendancy.

This young doctor located in the active village of Birmingham, needed not the eloquence of an Osler to teach him "The master word in medicine;" work he had always done, work of a masterful kind he was destined to do. Who can say what the initial incentive may have been; perhaps necessity, or maybe an ambition for wealth and its luxuries, or possibly in his boyish dreams he was allured by the Goddess of Fame. These, one or all, may have induced him to enter into the strife of life; but being in, there is naught in his whole career to belie the statement that he battled for the advancement of science in the cause of humanity. Early in his career we find him seeking knowledge at the side of the greatest clinical teachers in this country and abroad. Returning to his practice, he improved every available moment by laborious study. His restless and inquiring brain was not prepared to accept unreservedly the unsupported facts which find their way into medical literature. By close observation, experimentation and diligent research, he sought out the real truth for himself. Remote from university halls or laboratories, he pursued after his own way, amid inconceivable difficulties, original investigations. The association with Dr. Battey for a brief period, developed his taste for gynecology and abdominal surgery; and to this special field of work he devoted all his energies.

Recognizing the educational value of medical associations, he allied himself with the principal special and general societies in this country. Impatient because of their infrequent meetings, he and his brother organized the Alabama Surgical and Gynecological Society. Meeting with only indifferent support, he conceived the possibility of an organization of wider scope. To the accomplishment of this purpose, he bent all the energies of his enthusiastic nature and as the result, the Southern Surgical and Gynecological Association was organized in his office September, 1888; the revered Dr. W. D. Haggard, father of our honorable Secretary, was elected the first President, and Dr. W. E. B. Davis Secretary and active executive officer. From this hour Dr. Davis became the

most active man in medicine in the South. His conception of the needs for and advantages of such a society, was grand in its comprehensiveness. By personal appeals, tireless correspondence and frequent public addresses, he elicited the cooperation of every surgeon of present or prospective ability in the South; and throughout the period that he was most concerned in the upbuilding of this association, it had come to pass that he had in some way, either through kind and encouraging words or felicitous act, elicited the personal interest and individual aid of every member of our body. It must be remembered that, as Secretary, Dr. Davis' ideas of expansion ran counter to many. His motives were often misunderstood and sometimes impugned. Upon occasions he has defeated the wishes of his best friends, when he believed they were opposed to the best interest of the association.

It must not be inferred that Dr. Davis gave himself up to this evangelical work in society organizations and attendance. His character and reputation were attracting to him a large and laborious practice. He was recognized as a surgeon of clear conception, marked conservatism and unusual skill. His achievements in his special line of work were, indeed, often brilliant. His contributions to medical literature were numerous; always readable and instructive. Especially interesting are his various articles upon intestinal surgery.

In this presence it is not necessary to recount the various contributions to science from Dr. Davis. I must remind you, however, that in 1892 he experimented upon 200 dogs for the purpose of determining the safest and most expeditious treatment of common duct obstruction. The principles established by his conclusions are: That sterile bile is inoffensive to the peritoneum; that transperitoneal gauze drainage of the common duct is a safe procedure; that after removal of calculi from the common duct, suture of the duct is unnecessary, and indeed, harmful. These observations of Dr. Davis have lessened the dangers and simplified the technique of choledochotomy. It was not until six years after his work that Quenu found that symptoms of biliary intoxication developed after choledochotomy with suture of the duct wound and that these symptoms were relieved by cutting the sutures. Davis' conclusions were based upon original and painstaking experimentation, while Quenu acted under the emergency of desperate conditions and trusted to luck for the consequences. It is

gratifying to note that all surgeons in this country accord to Dr. Davis full credit for this distinct advance in this very difficult field of surgery. Our foreign confreres through their ignorance of our literature, have not made the acknowledgement due him. This signal observation of Dr. Davis places his name along with Bobb, Simms and Tate in the history of the surgery of gall stone, which in itself is sufficient to immortalize the man. Hepatic surgery was a favorite field of study and practice with our colleague, and his sudden taking off leaves incomplete his book upon this subject. Who can doubt that it would have been a prized contribution to our literature?

In all things Dr. Davis was a forceful man, but in nothing was this characteristic so strongly brought out as in our society debates. His advocacy of any cause was fearless. Quick to challenge all questionable statements, he would yield with sweetness and grace when in error. Intellectually combative and pugnacious, he spoke with candor and truth, and would tolerate nothing less in his adversary. His oratory was always serious and intense, at times eloquent, but not ornate. To him our society proceedings was too important a matter for frivolity, and, as Secretary, he would insist upon expunging from the minutes all things irrelevant or improper. How frequently have we seen him rise and remind us that "we are making history; we are writing a book."

For fourteen years this man labored for a definite purpose; and it is gratifying to know that he lived to see the realization of his hopes. Beyond this, his labor was unrequited. Should we not as a body, give expression to our approval and appreciation of his efforts in some becoming way? Our colleague was a provident man; his family are not in need of financial aid, but let us extend to the bereaved widow what she will value more—assurance of our sympathy and abiding interest. To his brother, our colleague, we offer the hand of true friendship, and encourage him to maintain the high name that they together have won. The little girls, Margaret and Elizabeth Davis, are wards of this association. Let us pledge ourselves as a body, to aid, shield and protect them through life.

As we recall the personality and the incidents in his career, we are almost persuaded that the life of Dr. Davis was set aside for a special work, and richly endowed with the attributes for its accomplishment. It is easy to point out here



and there other Southern surgeons possessing surpassing qualifications in limited lines of work; but view this life in its totality as it evolved from its crude state amid discouraging surroundings, shackled with poverty, without facilities save of his own making, unbaffled, he worked on and yet ere he had reached his fortieth year, he was rich in professional honors and dear to the hearts of his people. Surely this is success. Parallels there may be, but I know none such—Elias Davis was the foremost surgeon of the South. He came upon the sphere of action twenty years ago; and, as a master mason is chosen to square the corners and bridge the arches in our architectural piles, so he, the master workman in our profession, was appointed to construct the Southern corner of the amnificent edifice of national medical science.

For him our profession knew no sectional limitations. From the half dozen members of the Alabama Surgical and Gynecological Association, there evolved the Southern Surgical and Gynecological Association, geographically limited for a time, by Mason and Dixon's line. Now, we are a national body, and to his wisdom, activity, tact and courage we owe our present renown.

Whether I speak to you as citizen or man of science, it matters not. We are gathered from all parts of the Union with a common and single purpose—the advancement of science in the cause of humanity. No sectional lines divide us, no populistic theories infest us, no dreams of free coinage allure us, no problems of the races perplex us. Be you Puritan or Cavalier, New Yorker or Floridian, I say to you in the language of the great Lamar, "My countrymen, know one another and you will love one another." This was the spirit of Elias Davis. He loved the South and her people; he never wearied of singing the name and fame of her medical heroes. He was not content that the South should be known by a few illustrious names that tower like Alpine heights above all others. He strove to place Southern surgery upon so high a plane that none should shadow. He played the same part, though upon a differently appointed stage, essayed by the immortal Grady; and I say to you, he would have been known to the world as a patriot had he not been known as something greater—a physician.



## URINARY CASTS.\*

BY WM. LITTERER, A.M., M.D.,

Asst. to the Chair of Histology and Pathology, Vanderbilt Univ. Med. Dept.

Casts were first discovered in the urine by Vigla, Quevenne and Rayer in France; and almost simultaneously in Germany, by Nasse and Simon. A little later Henle discovered them in the urine of a dropsical patient, and afterwards demonstrated them in the uriniferous tubules of the kidney structure. But to Rovida, the profession is greatly indebted, for he has contributed the most ample information concerning their character and clinical significance. He suggests that casts are products of secretion by epithelium lining the urinary tubules, and his views are strengthened by the exhaustive experiments of Pollok and Torok; thus accounting for their presence in the absence of severe renal disease.

There are three theories, according to Purdy, that are ordinarily held as to their probable nature and mode of formation. The first theory is that they are the direct result of disintegration of the epithelium of the renal tubules, the resulting products becoming packed into molds by the pressure of urine until at length they slip through the smaller convoluted into the large strait tubes and appear in the urinary sediment. The second theory is that they consist of a secretion of the morbidly-irritated epithelium lining the renal tubules which cakes into molds, and the casts thus formed are washed down with the urine. The third theory is the one most generally accepted and is as follows: They consist of coagulable elements of the blood which gains access to the renal tubules through pathological lesions of the latter, and any free or partly detached products of the tubules become entangled in these coagulable products, assisting to form the molds of the tubules, which subsequently appear in the urine as casts. The last theory, together with the theory of Rovida are the most plausible ones, or at least that is applicable to the nature and mode of formation of most of the casts found in urinary sediment.

Taylor, of New York, says that although the substance forming the basis of casts is evidently closely allied to proteids,

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\*Read at meeting of Nashville Academy of Medicine, Tuesday, Feb. 2, 1904.

yet it is certain that it is not identical with any proteid with which we are at present familiar, as for example, albumin, acid albumin, albuminates, globulin, fibrin, mucin or peptone. Possibly it is a derivative of some of the above. It is now generally conceded that the Hyaline cast is the basis of all tube casts (with few exceptions). The others are named according to the kind of material or substance that is embedded in, or firmly adherent to this hyaline variety. Formerly the occurrence of hyaline casts in the urine was held to indicate the existence of Nephritis. This view has been abandoned, however, for the same reason which led to the theory that albuminuria invariably indicates Bright's disease.

In looking over the literature I find there is a great diversity of opinion among authors concerning the significance of hyaline casts, most, however, say their presence does not necessarily imply a pathological condition, while others as stoutly maintain the opposite view. We frequently see statements made in text-books that casts may appear in the urine of perfectly healthy individuals following severe muscular exercise, a cold bath, etc. Simon, of Baltimore, is of the opinion that these stimuli should not be regarded in every instance as functional, but should be looked upon as a pathological event. Taylor, a recent writer on this subject, in speaking of the opposing views of authors, says that "a critical survey of the whole field will enable us to see that in many instances each class of writers is right, but not always." The clinical significance of the presence of hyaline casts is open to many qualifying conditions and circumstances. First, they may be formed in the urine in those who are subject to irritable conditions of the urinary tubules. Second, circulatory disturbances as active and passive congestion, etc. Third, inflammatory involvement of the kidney. I shall first mention those conditions that are responsible for the irritation of the tubules. This irritation may be incident to those cases which have been subjected to altered conditions of the blood, as in all febrile states, toxines from the exanthemata, and from other bacterial diseases. Under this heading may be placed irritating drugs as cantharides, turpentine, ether, etc. Out of 109 operations at the City Hospital in which ether was used, the urine was examined in each patient several times before the operation, all of which gave negative results, both microscopically and chemically; but after the operation, eleven of the

above number showed a few casts, some of which were granular. However, all cleared up in ten days' time, or sooner. Now the question arises, why did not most of these patients have casts? I believe the solution is, that there exists some weakness that has not asserted itself heretofore, and should be regarded as a warning of prime importance. It is very probable that these patients will sooner or later fall victims of some kidney lesion.

Another source of irritation to the kidney that may excite casts, may be ascribed to the irritating substance conveyed by the blood, such as products absorbed from the stomach or intestinal surfaces, due to indigestion. The presence of toxins and changes due to defective metabolism. In this connection I will report Dr. H. G. Webster's observation as regards hyaline casts and cancer. He says: "In looking over the urinalyses of the last ten years at the Methodist Episcopal Hospital of New York, that he was impressed with the frequency with which hyaline casts were the only kidney symptom in Carcinoma, and is of the opinion that it is of the utmost importance if used as an auxiliary means of diagnosis as to the nature of a growth that does not always present malignant symptoms to the sense of touch and sight, if the hyaline cast can be recognized in the urine of a patient suffering with a suspicious condition." Fenwick, a recent writer on Carcinoma of the stomach calls attention to the frequency of renal disturbance occurring in the proportion of one in every three cases. I shall now briefly take up the circulatory disturbances of the kidney and will state that most investigators are of the opinion that the presence of hyaline casts occurring in small numbers and transitory are more frequently due to circulatory disturbances, either acute or passive congestion, in the kidneys than to true Nephritis. Osler in his paper on "Tube Casts and Albumin in Men Above 50 Years of Age," in speaking of the men following a strenuous life and having a mild circulatory disturbance, says "that in many cases the albumin and the few hyaline casts are simply the expression of 'mild decay' in the kidneys, and not of a condition serious enough to be called Bright's disease." In his conclusions he says "that the above symptoms are simply danger signals, the red lights which may mean an open drawbridge or a wrecked road ahead, but they may be simply warnings to the engineer to 'go slow,' that the pace is too rapid for the state of the track, and it is to the latter

significance of the red lights that he wishes to call attention." The most important points in conducting a microscopical examination for casts are to carefully ascertain their character and form, but more especially their size and their relative number to each other. In many cases, simply the size alone is of the utmost value in arriving at a difficult diagnosis, as well as prognosis, of the case.

I will attempt to put before you a condition which I have observed in four fatal cases of Nephritis at the City Hospital, and which is, I think, of great value in prognosis. These cases may be all unique, but occurring consecutively as they did, may be worthy of note. The cases in question were all acute Bright's disease, produced by or associated with the following conditions, viz.: Pneumonia, puerperal eclampsia, ether anaesthesia and typhoid. The four above cases showed a large number of exceedingly small contorted casts, a little longer than the average; some times sloping nearly to a point, usually granular, but some were epithelial and hyaline in character. In addition to the above, there were many very broad and medium sized ones, as are ordinarily observed in acute Nephritis. The main feature or significance of these cases was the presence of the very small contorted casts in an acute trouble, and I inferred that its source must be from the proximal convoluted and spiral tubules, and in order for them to accomplish their exit, they must pass through the very small descending limb of Henle, which has a diameter of only 1-2500 of an inch, as compared with a diameter of the convoluted tubule of about 1-500 of an inch. Hence, the smallness of the tubules and the vis a tergo of the urine is, I think, responsible for the small contorted casts. If we know that the proximal convoluted and spiral tubules are involved, which are regarded as one of the most important portions of the kidney, together with involvement of other portions as indicated by broad and medium casts, then the prognosis is grave, but often in acute Nephritis all the structures are not involved, which is very often determined by the character and size of the casts. In these latter cases the prognosis is much better. In chronic interstitial Nephritis the small cast predominates, due to contraction of the tubules by connective tissue; hence in these cases the above will not hold good. In the large white kidney we have a great many broad casts, due

to the denuded epithelial cells from the tubules which are capable of forming casts three times as large as when the cells remained intact.

I have devoted most of my time in discussing the hyaline variety, but for the lack of time have said little concerning the other very important forms. I will, however, make a few remarks relative to the granular cast. This cast, though a very important one, is some times misleading and does not always indicate an active destructive process within the kidney structure, as for example, suppose a few red blood corpuscles, leucocytes or mucous corpuscles should become broken down, all of which may occur in the practically normal kidney; now this broken down material or granular detritus may adhere to or become incorporated into hyaline casts, either within the tubules, in the pelvis or ureters, to say nothing of the various crystals and urates that may be a probable factor in the formation of this cast.

All of the above facts should be borne in mind, and we should not be too previous in pronouncing that the kidney is undergoing destructive change by observing the presence of a granular cast. For the above reasons I regard an epithelial cast of much more serious import than a granular one whose significance is not always a certainty.

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### *Abstracts.*

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#### ADRENALIN IN THE TREATMENT OF THE CARDIAC TOXEMIA OF PNEUMONIA.

The writer, Henry L. Elsner, M. D., of Syracuse, N. Y. (New York Medical Journal, Jan. 2, 1904), directs attention to the appalling mortality of pneumonia due to the resulting cardiac toxemia. The prime factor in this disease is a toxemia with obstruction in the pulmonary circuit, leading to cardiac asthenia. Marked changes occur in the right half of the heart, with far-reaching degenerative changes in the muscle, heart-clots, and vasomotor paralysis.

Three remedies meet the indications presented by the circulatory changes due to paralysis of the vasomotor centers, the dilated condition of the arteries and the weakened heart.

These are strychnine, digitalis and suprarenal extract or adrenalin, its active principle. Adrenalin acts on the heart and blood vessels favorably; it does not act on the vasomotor center. Hence, it may be used to assist strychnine. When the vasomotor center is exhausted and blood pressure study proves the inefficiency of strychnine, adrenalin may still be administered, and, in some cases which seem unpromising, when combined with the method of stimulation about to be suggested, we may carry the patient beyond the critical period to a safe recovery. Suprarenal extract, or adrenalin, has seemed to the author to act as a needed food in all infections where there is danger of myocardial degeneration. He reports a case of pneumonia, in a woman, the mother of five children, in whom it had been impossible to raise a continually lowering blood pressure with strychnine. The systolic blood pressure was almost immediately raised by the repeated administration at short intervals of fifteen minims of a one to one thousand solution of adrenalin hypodermatically, and the patient was saved.

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### LOCAL ANESTHESIA.\*

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BY F. GREGORY CONNELL, M.D.,

Surgeon to St. Vincent's Hospital, Leadville, Col.

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Local anesthesia is usually accomplished by freezing or by the injection of cocain or analogous preparations. The former is most unsatisfactory, owing to the pain of the freezing and thawing and the tissue changes which it causes.

The chief reason for the existence of the cocain substitutes is the danger with cocain of systemic poisoning from its absorption. Out of 250 reported cases of cocain poisoning, thirteen terminated fatally. The author himself had three cases of evil effects in a series of fifty cocain injections, while in a series of over eighty cases in which Beta-Eucain was the anesthetic used, no such symptoms were manifest.

Beta-Eucain has for its most characteristic and advantageous features the following: (a) Non-toxicity, the fatal dose being between 6 and 7½ grains per 2 1-5 pounds of body weight; there is practically no possibility of such a dose being injected in the course of an ordinary anesthesia. (b) It may be

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\*Abstracted from the Annals of Surgery, Dec. 1903..

sterilized by heat without the loss of any of its properties. (c) It will not deteriorate or decompose with keeping, and, (d) It will not increase the tendency to hemorrhage to any marked degree; vasomotor paralysis and secondary hemorrhage occur less frequently than with cocain. These points have been most influential in placing Beta-Eucain as the local anesthetic of choice, and its use is being rapidly increased.

The author further advocates infiltration anesthesia according to Schleich and that according to Braun, the latter combining adrenalin with cocaine or Eucain for this purpose. This combination has the advantage of a hemostatic action and of intensifying the anesthesia.

Regional anesthesia is also highly recommended. It is the injection of a 1 per cent. to 3 per cent. anesthetic solution into the sensory nerve that supplies the field of operation, usually at a convenient point between the central nervous system and the site of operative interference, though in some cases the nerves may be injected when exposed in the operative wound. A combination of infiltration and regional methods is usually employed, the former for the skin and the superficial parts and the latter by the direct injection into the nerve. When it is inconvenient to expose the nerve by dissection, an injection into the perineural tissue will, as a rule, be found ample and sufficient. The injection should be made into the region of the nerve to be interfered with and the nerve surrounded by what Matas terms an "anesthetic atmosphere." This "blocking," as shown by the splendid work of Crile and of Cushing on the subject of shock, also prevents centripetal impulses from reaching the center, thus removing one of the most important if not the chief cause of shock.

The advantages of local over general anesthesia are readily apparent. The former should be used as an adjuvant to, when not possible as a supplanter of, the latter. As Von Mikulicz has said, "the question of to-day is not which is the safer anesthetic, chloroform or ether, but in what cases can local anesthesia be substituted for anesthesia by inhalation."

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ARSENAURO.—Continued use of this most excellent preparation in diabetes has given the utmost satisfaction. From no other preparation or combination have we obtained such material results. Furthermore, in chorea, neurasthenia, and like pathological conditions involving the nervous system, it has proven most valuable.



## EXODIN, A NEW PURGATIVE.\*

BY PROF. WILHELM EBSTEIN, OF GÖTTINGEN.

Exodin, the diacetylrufigallic-acid-tetramethyl-ether, is a yellow powder melting at 180 to 190 C. It is odorless and tasteless, insoluble in water and with difficulty dissolved in alcohol. Since Jan. 13, 1903, I have experimented with it very extensively in the University and in my private clinic as well as in consulting practice. This paper is based upon numerous histories of more or less obstinate constipations in males and females of all ages.

The remedy never causes unpleasant by-effects, such as dyspeptic symptoms or eructations. It usually acts in from 8 to 12 hours. The unpleasant diarrheal discharges produced by many otherwise effective purgatives are absent in Exodin. In most cases the first passages are mushy and even solid. In the course of the next few hours there are usually from one to three more passages, the last being not infrequently thin. The faeces preserve their natural color. In extremely rare cases the first evacuations are diarrheal; entirely watery discharges were hardly ever observed. Once in a while the remedy may be ineffectual, but this is wholly exceptional.

The action of Exodin is midway between laxative and purgative. It can be used as an evacuant in simple constipation in otherwise healthy persons and also when sluggishness of the bowels is an accidental complication or a part of some other affection. In pregnancy, even during the first two months, Exodin has when all other laxatives failed proved very efficacious and harmless, effecting evacuation of abundant stools without any trouble. The use of the drug at intervals showed that it is always equally active whenever readministered. (A table here appended shows the action of the drug in 18 typical cases.)

For obvious reasons, a universal purgative suitable for all faecal retentions, will probably never be discovered. But the properties which Exodin exhibits enable me to welcome it as a most valuable purgative.

To find the indications for constipation remedies requires especially a careful abdominal examination. In my book on

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\*From the Göttingen University Medical Clinic. Read before the Göttingen Medical Society, Dec. 3, 1903; abstracted from the Deutsche Medizinische Wochenschrift, Jan. 1, 1904.



Chronic Constipation I have gone fully into all the points involved. There is too much routine prescribing done here; those who are perpetually talking and writing against quackery must not forget the importance of depriving the quacks of their weapons.

Too much must not be demanded of Exodin. We cannot expect the intestines to react at once to the purgative in cases of old chronic coprostasis which is kept up by hard and dried scybalae accumulated in the large intestines; or in spastic constipations in which the spasm of the intestinal muscles prevent defecation; or where paralytic conditions cause the retention. When the intestinal canal is weakened, its refusal to perform its functions becomes more and more obstinate as we irritate it, either by large doses of mild purgatives or by the always reprehensible method of employing so-called drastic evacuants. When hardened faecal masses are accumulated in the large bowel and purgatives are ineffectual, the so-called high-oil enemata are indicated. But the acid content of the oil, increased though it is in the gut, is not infrequently unable to irritate the large intestine sufficiently to cause the expulsion of the faeces. To aid in this, I employ purgatives which I call "propellers" and which are extremely important in the treatment of chronic coprostasis. A proper combination of the oil with them must be made, care being taken to strengthen and not to weaken the intestinal action. In my book on Chronic Constipation I gave a list of the propellers at that time known to me.

The result of very extensive experimentation with Boudard's ricinine pills has caused me to reject them. But Exodin has done me excellent service as a "propeller;" since I use it for that purpose I have completely given up calomel and castor oil. Frequently 15-grain doses of the remedy sufficed with oil enemata to secure satisfactory evacuations. (A table showing the results obtained in six cases of coprostasis in which 15-grain doses of Exodin was used with oil enemata of up to 10 ounces, is appended.

Over purgatin and emodin (see my report on both remedies in the *Therapie d. Gegenwart*, January, 1902) Exodin has the advantage of greater efficiency, results being obtained with smaller doses. Besides, it does not make the urine staining, to which women, for readily understood reasons, so strongly object.

Patients suffering from the severest forms of chronic constipation who had tried all possible remedies and whose judgment was unimpeachable preferred Exodin on account of its prompt, painless and efficient action to all other medicaments.

I made an extensive series of experiments with Exodin, adding it to the oil enemata, but the administration by mouth seemed to act better.

Exodin is marketed in the form of  $7\frac{1}{2}$ -grain tablets, which are tasteless and odorless. One tablet is enough for children. Adults take from one to three tablets; two, however, are usually sufficient to produce one or several mushy stools within 8 to 12 hours. The tablets should be allowed to disintegrate in a suitable quantity of water and the mixture drunk under constant stirring with a spoon. Any Exodin remaining in the glass should be rinsed down with additional water. This method insures the introduction of the remedy into the stomach in the finest possible state of subdivision.

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## *Clinical Reports.*

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### CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

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STATED MEETING HELD JANUARY 4TH, 1904.

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The Vice-President, Dr. D. S. Dougherty, in the chair.

*Primary Endothelioma of the Lung and Pleura.*—Doctor Maurice Packard presented this patient, of whom he gave the following history: Male, aged 24 years; cigarmaker by trade. Father died of endocarditis, sister of apoplexy, brother of diabetes. No history of tuberculosis in the family. The patient gave no history of syphilis or of alcoholism, and claims he was never ill until the present time. About five years ago he began to cough, with very little expectoration, but otherwise was perfectly healthy until fifteen months ago, when the cough became more distressing and was accompanied by profuse expectoration. He became very short of breath, especially on exertion, and suffered from pains localized anteriorly on the

right side. These pains were increased on deep inspiration. There were no night sweats, nor, at that time, any hemoptysis or loss of weight. Although the examination of the sputum was negative, he was sent South with a diagnosis of tuberculosis. As there appeared to be no improvement, he remained but a short time. The symptoms continued about the same, but he noticed that the veins of his chest and abdomen were growing larger, and that when he coughed he brought up considerable blood, sometimes as much as a cupful. His sputum examination was still negative.

Dr. Packard saw him for the first time about two months ago, and his examination developed the following: The man was fairly well nourished, but had peculiar varicosities on the chest and abdomen. His right lung did not expand as well as the left, and there seemed to be a change in the dimension of the thoracic arch. Pectoral fremitus was diminished on the right side, from the second to the fifth intercostal space, and from the sternum to the axillary line. Over this area the percussion note was flat, but over the other portions of the same lung and over the left lung it was almost normal. Vocal fremitus was diminished, and distant bronchial almost tubular breathing could be heard over this affected region. Over the other portions of this lung the sounds were normal. The heart, spleen, liver and abdominal organs were normal. Sputum examination and thoracentesis were negative; the urine was normal. One month ago signs similar to the above were found posteriorly in the lower lobe of the right lung.

*Erythromelalgia.* — Dr. J. C. Lynch presented this case of Wier Mitchell's disease or erythromelalgia, occurring in a man 51 years of age, who was also the victim of tabes. The patient was single, and an officer in the navy. He had had the ordinary diseases of childhood. During adolescence he had pneumonia twice and typhoid fever. While on a cruise to the Far East he had Chinese malaria (?). (From his description one would be warranted in presuming that it was lues). Since he was 20 years old and up to the present time he had been free from sickness, except for three attacks of tripper. After the Spanish-American war he noticed that he had difficulty in holding his water (hurried sphincteric action), which was shortly followed by difficulty in walking (ataxic gait), accompanied by sharp, shooting, stabbing pains in the feet and legs

(lightning pains). On consulting the ship's surgeon about his difficulty in walking he was told he was suffering from beginning gangrene of the left foot. He was put to bed and his condition improved. Six months later the other foot became involved. The first two toes were then amputated. After recovery from this operation he retired from the service.

*Acute Thyroidism Following Curettage.*—This case was reported by Dr. Brooks H. Wells. He said that since the time when the Roman matron measured with silken ribbon the throat of the bride before and the day after marriage, to determine by its rounded increase that she had been a pure virgin, the sympathetic relation of the thyroid gland to the pelvic organs has been vaguely known; but hardly more than a decade has passed since we began to appreciate the various facts that will in time lead to an accurate knowledge of the functions and physiology of this and the other ductless glands.

Under certain conditions there occurs in those individuals who have been the subjects of a thyroid tachycardia a virulent, acute toxemia, characterized by a well-marked group of symptoms. This toxemia may follow operations upon the thyroid itself, operations upon the pelvic organs, or, more rarely, operations upon the breast or other parts of the body, or any marked nervous strain.

The exact mechanism by which the function of the gland is disturbed or excited is not definitely known. The disturbances after operations on the thyroid itself have been attributed to an outpouring of toxic material into the blood, either as the result of the manipulation to which the gland is subjected or from a leakage and absorption from its cut surfaces. These causative factors can be ruled out when the thyroidism follows operations on other parts of the body. In cases similar to the one recorded below it seems certain that the condition is the result of a reflex disturbance of the central nervous centers and the sympathetic centers that control the activity of the thyroid gland or, as has recently been suggested, of the parathyroids.

The condition is often rapidly fatal, death occurring within the first three or four days from cardiac exhaustion. When recovery ensues the symptoms rapidly or gradually disappear until the individual reaches the status present before the attack.

The following case of acute thyroid poisoning following curettage seemed to possess features of interest which made it worthy of record.

Mrs. X., aged 53 years, had passed the menopause at the usual time, but during the last six months had had repeated small bleedings from the uterus, which was not enlarged, and was freely moveable. She was nervous, thin and poorly nourished. For many years she had had a slight enlargement of the right lobe of the thyroid, an excitable, rapid pulse and slight tremor, but no protrusion of the eyeballs. Auscultation of the chest revealed a few bronchial rales. No other pathological condition was discovered. To exclude the possibility of beginning cancer of the fundus uteri as a cause for the post-climacteric bleeding, a curettage of the uterus was performed under strict asepsis on November 5, at 10 a. m. The scrapings from the endometrium were examined by Dr. Jeffries, Pathologist at the Polyclinic, who reported that they showed only a moderate grade of endometritis. There were no further symptoms, local or general, that could be referred directly to the curettage.

The anesthetic was given by Dr. Bennett, and was gas followed by ether. After a few breaths of ether her heart became so rapid that Dr. Bennett considered it wise to change to chloroform, under which the heart beats became slower. From the beginning of the anesthesia to the return to consciousness a little less than half an hour elapsed.

Six hours later the patient was flushed, tremulous, nervous, voluble, but not worried and with mind clear. Her pulse had risen to 130 and became more rapid on any little excitement. Temperature 100.5 degrees F. Twenty-four hours after the operation the flush, tremor, nervousness and volubility were increased; the pulse had risen to 178 and at times was uncountable; her temperature was 99.5 degrees F., there was profuse sweating, a watery diarrhoea, marked irritability of the bladder with polyuria, many soft rales all over the chest, and vomiting. The thyroid was perceptibly enlarged, especially on the right side, and presented a quite apparent thrill. There was marked throbbing of the heart and large arteries. Examination of the urine showed a sour odor, reaction neutral, sp. gr. 1012, no albumin, no casts, innumerable colon bacilli, and a few pus cells. These symptoms of an extreme toxemia continued to the end of the first week, when her temperature

reached 101.6 degrees F., and the auscultatory symptoms of bronchitis became more marked, though there was little cough and little expectoration. Blood examination at this time showed no leucocytosis and no typhoid reaction.

From the fifteenth to the twenty-fourth day the patient's condition was such that death was expected to occur at any time. The toxic symptoms continued, the tongue became dry and brown, there was extreme weakness and the usual relation between temperature and pulse was reversed so that the most rapid and weak heart action was when the temperature was lowest. The diarrhoea ceased to be troublesome on the twenty-first day, and on the twenty-fourth the patient was able to take small amounts of solid food by mouth. From this time on improvement was steady, but slow, until she reached a condition approximating that before the operation.

Treatment.—At the beginning it was thought that some of the symptoms might be dependent upon an intestinal toxemia, and the patient was given calomel followed by a saline and repeated high colonic flushings. The bladder for several days was washed out with a boric acid solution at eight-hour intervals, the washing being followed by the injection and retention of two ounces of a 10 per cent. argyrol solution. The diarrhoea was finally controlled by tannigen by mouth, ten grains every three to six hours as needed, and starch and deodorized tincture of opium, ten minims, by rectum, every six to eight hours. The insomnia was relieved by the opium and by trional at night, in doses of from twenty grains at first to five grains at a later period. As it became impossible to make the patient retain food given by mouth, rectal alimentation was employed more or less from the eleventh to the twenty-second day. Solid food in small amounts was given on the twenty-fourth day. The heart action and general condition were not benefited by any drug; colonic flushing, strychnine, digitalis, belladonna, superarenalin, alcohol, all seemed to do more harm than good.

Dr. Robert C. Myles opened the discussion of this case. He said that one of the peculiar characteristics of exophthalmic goitre is the diminished electrical resistance. If some one would experiment with these cases in order to find out, if possible, what alkaloid was discharged into the system, and its exact relation to the thyroid, the speaker thought these cases could be treated more successfully.

*Leprosy.*—Dr. F. Dillingham presented a patient, male, aged 58 years, who was born in America, and has lived here, with the exception of one year spent in Mexico, during his entire lifetime. Eight or nine years ago a corn appeared on his right foot. It began to burn and in a short time a perforated ulcer developed. He had the joint excised, and two years afterward the second joint was also treated in this manner. Two years later a second ulcer appeared on the other side of the same toe. There are now two perforating ulcers present. This was about all the history the patient could give.

The speaker said that the diagnosis can easily be made from the typical picture presented and by exclusion of any other condition, because of the lack of essential conditions. The brownish patches here and there and the peculiar brownish color and scaling appearance of the limb were characteristic of leprosy. There was more or less atrophy of the foot and also of the hand, but very little loss of sensation. He said there were three types of leprosy, and gave the differential symptoms minutely. The question of contagion was interesting in these cases. In some countries leprosy undoubtedly is contagious, but, in his opinion, this is not true in our climate. There are several cases in this city all the time, and no case has been reported that has developed as the result of contact with another patient suffering from the same condition. He once saw a patient in whose case he made a diagnosis of leprosy, and she informed him that her husband had suffered from the same condition before it developed in her. In countries where leprosy is prevalent, people who have proper food and proper hygienic surroundings very rarely contract the disease. Some authorities claim that it is infectious, some that it can be conveyed only by direct contact, and some that it is a concomitant of yellow fever and malaria. Experiments have been made by having lepers breathe into a certain receptacle, and colonies of bacteria have been grown from the atmosphere into which they breathed, showing that the mucous membrane of the mouth may be the source of infection. Inoculation, as a rule, has been negative. The speaker succeeded, some years ago, in inoculating some persons with leprosy, but there was some doubt about its being a leprous family, so that experiment proved nothing. Some guinea pigs were inoculated with tuberculous nodules, and eight months later bacilli were found in the kidneys, spleen and liver.



The duration of the disease varies, according to the form. Some patients live twenty years after the symptoms appear. The patient before the Society had suffered from this condition for about nine years, and, except that it was rather inconvenient for him to get about, he was not incapacitated for work.

*Cast of a Bronchial Tree.*—Dr. F. M. Jeffries presented a cast of a bronchial tree. He said that the cast was from a patient suffering from fibrous or plastic bronchitis. It showed the ramifications of the smaller bronchial tubes. The speaker said that it was the first specimen of the kind he had seen in a laboratory experience of twelve years, and for this reason he thought it worthy of note.

*A New Method of Treatment for Fracture of the Neck of the Femur.*—The paper of the evening was read by Dr. Royal Whitman. He called attention to the fact that it was generally admitted that the results of treatment of fracture of the neck of the femur are very unsatisfactory. These results are to be ascribed, not so much to the age of the patient or to the severity of the injury, as to the faulty conception of treatment and its perfunctory application. At present it is taught that no attempt should be made to correct the deformity of an impacted fracture, a deformity which is essentially a traumatic coxa vara; while the means employed to appose the fragments and to hold them in position, if the fracture is complete, are quite ineffectual, as demonstrated by the fact that shortening is almost always present when the treatment is concluded. He said that fracture of the neck of the femur is not uncommon in childhood and in vigorous adult life, but as it is often incomplete, it is usually classed as a contusion. These cases are unrepresented in hospital statistics.

The treatment which he had already described as applicable in childhood (*Annals of Surgery*, November, 1902), he would, on further experience, now urge as one of routine in all favorable cases. In principle, it is a method of replacing the depressed neck, if the fracture is incomplete or impacted, and of apposing and retaining the fragments in approximate apposition if it is complete. If the fracture is impacted, the patient having been anesthetized, the extended limb should, under traction, be slowly abducted. As in every instance in



which depression of the neck is present, abduction would be checked when the neck comes into contact with the upper border of the acetabulum, further forcible deduction by means of the leverage of the extended limb on the fulcrum of the acetabulum would disengage the impaction and elevate the neck. At the limit of normal abduction a long plaster spica bandage should be applied. If the fracture is complete the shortening should be reduced by traction and countertraction. The limb should then be abducted, and by downward pressure on the trochanter the outer fragment may, if of sufficient length, be pushed beneath the rim of the acetabulum. Abduction should then be increased until the trochanter is brought into contact with the side of the pelvis, so that upward displacement is impossible. In this attitude it is evident that muscular contraction becomes powerless to induce deformity, while the firm support of the plaster bandage permits necessary movements without danger of displacement. The details of the treatment and the after-treatment were described and the modifications that might be necessary to meet varying indications. In closing, the reader again called attention to the large number of patients, still youthful or in vigorous old age who, because of failure of diagnosis and inefficient treatment, were in great degree disabled by this injury. He said that the limitations of weakness and age so often urged as an excuse for the present ineffective and perfunctory treatment should attempt to apply here the principles that are admitted as being essential to the successful treatment of fracture in other situations.

Dr. J. A. Bodine opened the discussion of this paper. He said that it was particularly interesting to him because he had control of practically the largest fracture service in the country at St. John's Hospital, Long Island City. Some years ago he had been called to see a patient who, as far as he could make out, had sustained an injury to the patella ligament, and there was relaxation between the patella and its insertion. He had never been told that fracture of the neck of the femur was a condition of young life, and sent the patient to Dr. Whitman, who made the diagnosis. Most of the patients were 40, 50 and even 60 years of age, who were included in the speaker's service, and were thin and emaciated for the most part, and an anatomical cure was more than could be hoped for. If these patients could get about with the limb supported

by a high shoe, the surgeon had to be content, but in future, the speaker would be glad to try Dr. Whitman's method. About two years ago Dr. Maxwell reported several cases in which he put on twenty to thirty pounds pressure to reduce the shortening, and in addition lateral extension of some ten pounds, as he claimed that in case the neck of the bone was pulled down, a better position resulted. He showed four post-mortem specimens secured from patients who died some years after this method was applied, which showed almost perfect union. Dr. Whitman claimed these ends could be brought into apposition. His method possessed a great advantage over others. But in young people why not use direct operative interference? The surgeon can cut down, certainly, on the great trochanter.

Dr. Alexander Lyle said that he was surprised that the writer of the paper advocated the breaking up of an impacted fracture. He thought that the age and general physical condition of the patient should be taken into consideration before adopting it. He was sure that if the general conditions were unfavorable, it would not be justifiable to release the impaction. He had noticed that fractures of the neck, near the trochanter, are almost invariably impacted, and those near the head of the femur are not impacted, which might be an important point in diagnosis.

In reply to Dr. Bodine, Dr. Whitman said that twenty-six cases of fracture of the neck of the femur in childhood had come under his observation, and that in a single year he had seen five cases in young adults in not one of which had the diagnosis been made. He was not ready to admit that because a person 60 years of age, treatment was useless. Direct operative intervention is, of course, a treatment of last resort, that may be applied only under favorable conditions. It, however, might be the treatment of selection for partial epiphyseal separation in young subjects.

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AN ELEGANT LITHOGRAPH in eleven colors of a medicine man of the Sioux Indians has been sent to every physician in the United States by the proprietors of the Tongaline Preparations and Ponca Compound. Any physician who has not received this handsome and artistic reproduction of a famous Indian chief can easily obtain such by writing for it to the Mellier Drug Company, St. Louis.

## REMOVAL OF UTERINE FIBROID DURING PREGNANCY.\*

M. C. MCGANNON, M.D., OF NASHVILLE, TENN.

I am indebted to Dr. McCampbell, for referring to me, the patient from whom I removed this tumor, that I have the honor of presenting for your consideration this evening.

The patient was a young woman, who, on Oct. 2, menstruated for the last time. In the early part of December she came to Dr. McCampbell, complaining of nausea. He made a diagnosis of pregnancy and gave something to relieve the nausea, and the patient passed from his observation for the time being.

On Friday last, she again sent for the Doctor, because of severe pain in the left side. She had, for a month, suffered with pain in the left ovarian region, but it was not severe until ten days ago; since which time it has increased in severity. The distress was ever present, but became much increased by movement. Upon examination, the doctor found a tumor in the left inguinal region. The patient was then referred to me.

When she came under my observation, examination demonstrated enlargement of the mammae with the areola darkened and the papillae about the nipples enlarged. The abdomen, in its lower zone, was enlarged and moved but slightly during the act of respiration. The abdominal muscles were somewhat tense, and tenderness was marked over the lower part of the abdomen. An elastic tumor was easily palpated on the right, filling the lower abdomen beyond the median line to the left, and extending more than half way to the umbilicus. On the left side, a rounded mass, which was fixed, filled the space between the tumor already described and the pelvic wall. It did not rise above the anterior superior spine of the ilium. This tumor was hard, but its density and its outline could not well be defined, because of the tenderness and rigidity of the abdominal wall. A diagnosis of uterine fibroid, with peritonitis and adhesions binding it and the uterus to the pelvic region, was the diagnosis, and operation for its removal was advised and accepted.

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\*Read at meeting of Nashville Academy, Tuesday, April 9th, 1904.

The abdomen was opened in the median line, by a four-inch incision extending from below to within two inches of the umbilicus, exposing the red, succulent pregnant uterus, with its right horn pushing upwards and forwards, its left downward and backwards, behind a fibroid tumor which was fixed to the pelvis in such a way as to hold the uterus in this rotated position. The adhesions were not old, and were easily separated by the fingers. As soon as the tumor was separated from its attachment on the pelvis, the left horn of the uterus arose in the abdomen to its normal level, and at the same time rotated forward, carrying the tumor with it, so that the latter's pedicle was in the center line and underneath the upper angle of the abdominal incision.

The tumor was then grasped and withdrawn from the abdomen, when it was seen to have the omentum adherent to its upper and outer part. This was easily freed. I opened the tumor capsule on one side, about a half inch from the uterus, and then dissected the tumor from its bed, leaving sufficient capsule from the opposite side, to form a flap, with which to cover in the raw surface in the uterine wall. A double row of catgut sutures closed the opening and stopped all bleeding. The abdominal wall, I closed in layers, using catgut and silk worm gut for the purpose.

Ordinarily, one would not find it necessary to remove a tumor the size of the one presented, whether the patient was pregnant or not; but the conditions seen in this case seldom occur in fibroids, complicating pregnancy.

Cystic degeneration was present in this growth, with peritonitis and adhesions to the pelvic wall, and also to the omentum. The uterus, as a result, became a fixed organ, and incapable of uniform development to accommodate the growing child.

Furthermore, the organ being rotated upon its own axis, necessarily must sooner or later have suffered interference with its blood and lymphatic circulation; hence, an abortion might reasonably have been expected to follow.

If pregnancy proceeded to term, a difficult labor, causing rupture of the uterus, or necessitating a Caesarian section, might have resulted.

## CLINICAL OBSERVATIONS AND REPORTS OF CASES ON GLYCO- THYMOLINE.

BY H. S. P. LARE, M.D., OF ST. LOUIS, MO.

The value of Glyco-Thymoline to the clinician to-day has been recognized by the profession since its introduction a few years ago. As a purgative for the various mucous membranes of the body, Glyco-Thymoline fills a long felt want in the physician's armamentarium of tried and deserving therapeutic agents, being safe and efficient, its action is definite and positive.

Glyco-Thymoline, acting as it does on the theory of exosmosis, is the rational, logical theory of health, depleting inflammatory engorgements by this process, increasing capillary circulation and maintaining strict aseptic cleanliness of the mucous membranes of the body whenever applied. The conception or creation of Glyco-Thymoline, I consider a scientific achievement, as when it is liberally diluted with distilled water, possesses the saline strength and alkalinity similar to that of the human blood, therein lying the great secret of success of this most potent remedial agent, for it is a well established fact to every physician that any topical application to be beneficial and successful, must harmonize with the natural fluids of the tissues to be treated.

In this respect Glyco-Thymoline stands pre-eminently in the foremost ranks of therapeutic resources at the physician's command, readily dissolving accumulated mucus, detaching mucus crusts and necrosed tissue.

Having satisfied myself beyond the shadow of a doubt, that Glyco-Thymoline as prepared by Kress & Owen Co., of New York City, is by far the most efficient purgative for the mucous membranes extant, I append herewith to my clinical observations, reports of cases as they occur in my daily ledger.

Case I.—Mrs. Etta L., aet 28, married, mother of three children, complained of dizziness, backache and pains in thighs, a constant offensive leucorrhea.

Examination revealed an enlarged uterus with great tenderness of the cervix. I diagnosed the case as one of Endocervicitis.

After prescribing a purgative and tonic course of treatment, I treated her locally with Glyco-Thymoline two parts, and water one part.

Applied cotton tampon or pledgets thoroughly saturated with the Glyco-Thymoline mixture.

I pursued this treatment three times per week, instructing patient to use warm water vaginal douche after withdrawing tampon at the end of forty-eight hours, the douche being medicated with about one-half ounce of Glyco-Thymoline to every pint of warm water used. In ten weeks' time I had the satisfaction of seeing my patient fully restored to health.

Case II.—Mrs. Lulu W., widow, aet 40, mother of two children, ever since birth of her last child has been troubled with menstrual irregularities. Had constant "whites" as she expressed it. Upon examination I found a slight retroflexion and oozing from the cervical os. I corrected the retroflexion by the application of a pessary and applied locally Glyco-Thymoline, thoroughly saturating pledgets of cotton with the same. Gave constitutional treatment in the nature of iron and mineral acids, and was rewarded by seeing her make a speedy recovery in about six weeks' time.

Case III.—Mrs. Flora M., aet 36, married, mother of one child, a boy, consulted me professionally about an itching of the vulvae; menses were very slight and burning as they passed from her every month.

Examination revealed an aggravated case of pruritus. Placed her under treatment by giving a wash of Glyco-Thymoline (Kress), glycerine and rose water, equal parts. In three weeks the pruritus had disappeared.

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X-RAY PRIZE ESSAYS.—Believing that the further development of X-rays is of great importance to surgery and medicine and the human race, and to encourage research and disseminate the knowledge gained, the *Illustrated Review of Physiologic Therapeutics* offers the sum of fifteen hundred dollars in cash prizes for the best essays on X-rays in medicine and surgery, the first prize being \$1,000. All surgeons, physicians, and hospitals interested in any branch of X-ray work should write to the *Illustrated Review of Physiologic Therapeutics*, 19 East 16th Street, New York City, for information concerning title, time allowed, conditions, etc.

## *Records, Recollections and Reminiscences.*

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### REMINISCENCES OF THE MEDICAL DEPARTMENT, CONFEDERATE STATES ARMY.

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BY EDWIN D. NEWTON, A.M., M.D., OF SAVANNAH, GA.

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The history of "The Southern Confederacy" is incomplete without a sketch of the surgeons and "The Surgery" of its Army and Navy. A comprehensive view of the same, however, was presented by Dr. Samuel Preston Moore, Surgeon General C. S. A., at a meeting of "The Association of Medical Officers of the Confederate Army and Navy," at Richmond, Virginia, 1875. The story of the lives and services of the Confederate Surgeons, for many reasons, is imperfect, we can only "gather up the fragments" of the same. The Medical Department of "the Army of the Confederate States" was formulated at Montgomery, Alabama, immediately after the organization of the Confederate Government, and Dr. D. C. DeLeon, a member of one of the most distinguished families of Mobile, Alabama, and a surgeon-resigned from the U. S. Army, was appointed Surgeon General. Upon the removal of the capital of the Confederacy to Richmond, Virginia, Dr. DeLeon was succeeded by Dr. S. P. Moore, who was his superior in rank in the Medical Corps, U. S. A. From that time until the end of the war Dr. Moore retained his position as Surgeon General. His administration was a marked success, though the difficulties and environments were of the most perplexing character. We refer to his postbellum address, above mentioned to verify my "encomium." A recent letter from Dr. Francis Sorrel (of Savannah, Georgia, originally), who was an old U. S. surgeon, and a member of the immediate staff of Surgeon General Moore, kindly gives us some light upon the events of the Medical Department, years 1861-5. I present the letter, as I know that it will be received with peculiar interest by his surviving comrades, his brother surgeons of the C. S. A.



(Copy.)

"THE BARRENS,"

Near Roanoke, Va., March 28, 1902.

Dr. E. D. Newton, Milledgeville, Ga.:

My Dear Doctor—I am just in receipt of yours of 22d inst., and without delay send you a meagre statement of the facts within my knowledge. At the outbreak of the late Civil War I was a member of the California Legislature, in which State I was then residing. On its adjournment late in June, 1861, I made my way to Richmond, Virginia, where I reported, offering my services in the Medical Staff of the Army. Having served seven years in the U. S. Army, I was immediately appointed a surgeon in the regular army, and ordered to report to Surgeon General S. P. Moore, which I did on the 15th of August. Everything connected with the army was in a state of chaotic confusion; sick and wounded from the recent battle at Manassas arriving in large numbers, while new troops were pouring in from the South, developing, of course, the usual zymotic and camp diseases. I was put to work at once to assist in the organization of the corps, and subsequently was given direct charge of the system of General Hospitals. With Dr. Moore were Drs. Smith, Williams and Brewer, of the old U. S. Army. All of the "Pavilion Hospitals"—"Chimborazo," "Camp Winder," "Howard's Grove" and various tobacco factories, were organized under my care and superintendence. The following spring I was sent to General Albert Sidney Johnson's headquarters, along the line from Chattanooga to Corinth, in order to organize hospitals in the rear of the army, extending to and including nearly every town and city south and towards the Gulf; so that when the battle of Shiloh came our Department was prepared for the heavy calls made upon it. Returning to Richmond I was given a corps of disabled soldiers as clerks, and put in charge of all the general hospitals east of the Mississippi. In my office, on Bank street, were prepared my volumes of classified and tabulated gunshot wounds and injuries, which were unfortunately destroyed by fire at the final evacuation. These records, if preserved, would have proved a noble testimony to the high professional skill and success of the surgeons.

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I am almost the only survivor of my day and generation. Hailing only from California, on entering the Confederate States, my position has been somewhat prejudiced in the



Association of Veterans by my name not appearing on the list of any of the Southern States. In the volume "Virginia," of the Confederate Military History, published at Atlanta, you will find a sketch of my life. To it I refer you. \* \* \* \*

Now, my dear Doctor, little used to writing, and suffering from a gouty wrist and hand, it is really a punishment for me to do so. I hope, however, you will find some compensation in what I have written. Should you ever pass this way, stop and see me. Meanwhile believe me, faithfully yours,

(Signed.)

FRANCIS SORREL.

P. S.—My assistant is preparing "Records," Dr. Herman Bear, Charleston, South Carolina, died a few months ago. Dr. J. R. Reed, a noble gentleman and skilled surgeon, resides at present in Florida.

During the battle around Richmond, there were cared for in the hospitals in that city, with its population of only 40,000, 20,000 sick and wounded. Napoleon in his campaign of 1814 thought the resources of his capital city of Paris were overtaxed when the numbers of his sick and wounded reached 10 per cent. of its population.

Dr. Williams (of U. S. Army, resigned) was Medical Director of the Army of the Potomac, commanded by General Joseph E. Johnston. When General R. E. Lee was appointed to the command of the Army of Northern Virginia, (General Joseph E. Johnston wounded in battle of Seven Pines), Dr. LaFayette Guild (an old army surgeon) was appointed Medical Director of the same, and retained his position from that time until the final surrender at Appomattox Court House. His "occupation gone" as a military surgeon, he entered hospital service at Mobile, Alabama, and afterwards in Oakland, California, where he died. His remains, however, now rest in his beloved native State, and at his old home, at Tuscaloosa, Alabama. Just before the Gettysburg campaign, General Lee reorganized his army by adding the Third Army Corps, under General A. P. Hill. Dr. J. W. Powell, of Columbia, South Carolina, was selected as the Medical Director of this corps. The writer of these lines, in recalling his brother medical officers, has not been able since the close of the war to locate Dr. Powell. Very recently, however, through our ex-President, Dr. Francis L. Parker, of Charleston, S. C., and Mr. F. Powell Hinnaut, of Ridgeway, South Carolina, a relative of Dr. Powell, we find that he, at the close of the war, made Hernando, Mississippi,

his home. During the epidemic of yellow fever in 1878, he ended his life, dying at his post as a physician. Dr. Powell was a typical Southern gentleman and an excellent surgeon. Educated at Furman Institute, graduating at Charleston Medical College, subsequently attending the colleges North, and also enjoying the year 1858 and 1859 in the European schools of medicine and surgery.

The Medical Director of the First Army Corps (Longstreet's), Dr. J. S. Cullen, was well known by all his brother medical officers in Lee's Army. An accomplished gentleman, well posted in his profession, he illustrated his ability during the four years of arduous service by the successful administration of his affairs as the chief surgeon and medical director of his corps.

Dr. Hunter McGuire, Surgeon and Medical Director Second Army Corps, was too well known for me to mention his merits as a surgeon of the highest character and skill. His name will ever be associated with "The Napoleon" of the war between the States, General Stonewall Jackson.

Dr. McGuire, we may mention, was also a prominent actor in the great revolution of 1860, for it was he and his friend and associate, Dr. Ed. Lockett, of Virginia, who led the Southern students to withdraw from the Jefferson Medical College and the medical schools in Philadelphia, owing to the local hostility of its people toward the South.

Dr. J. B. Fontaine, a Surgeon and Medical Director Cavalry Corps, Army of North Virginia, was one of the noblest, most knightly men I ever knew. He was an able and efficient medical officer and prompt in the discharge of his official duties. Nothing, however, could restrain him when the bugle sounded the charge, and through his gallantry and his attention to a wounded officer, General Donavan, of South Carolina, who had fallen, he, too, was fatally stricken at his side.

Commissioned by the Secretary of War as Assistant Surgeon at Montgomery, my first service was at General Hospital No. 1, Richmond, Virginia; Charles Bell Gibson, surgeon in charge. My senior surgeon, my associate in the hospital, was Dr. St. George Peachy, of Richmond, an accomplished military surgeon, one who had seen service in the Crimean War, and served in the hospitals of the Allied Army at Scutari and elsewhere. He and Dr. E. J. Eldridge, senior and Brigade Surgeon of Cobb's Brigade, were the only two surgeons (outside

of the surgeons of the old U. S. Army) of my personal acquaintance who had had experience in military surgery on entering the Confederate Army. Dr. Eldridge was a surgeon in the Russian army hospital at Sebastopol.

Five hundred Federal wounded from the battle of first Manassas, including Capt. Ricketts, Col. Orlando B. Wilcox, First Michigan Infantry, and Major Potter. These received the best attention and most skillful treatment possible. I trust that I may be allowed to mention the fact that I here introduced, the anterior splint of Dr. Nathan R. Smith, of Baltimore, to the military surgery of the Southern Army, (patient a teamster of Eighth Louisiana, fracture of femur, by a runover by army wagon, which occurred some time before the battle of first Manassas. Seeing my application of said splint, Surgeon General Moore selected a commission of surgeons for its examination, and it secured their unanimous approval.) The Handbook of Military Surgery, by Julian J. served as a text-book and guide to all Confederate surgeons, field and hospital, throughout the entire Confederate Army. We cannot say too much of the noble and unselfish devotion of the gentle ——— the Catholic Sisters from the Maryland Chisholm, of South Carolina, was a masterly production and hospitals, who gave their services to this hospital and others in Richmond, Sister Valentine, the Sister Superior. They remained in Richmond till the close of the war, embracing, a period of four years. In this brief sketch it is impossible for me to mention the names of all our noble physicians and surgeons of the Confederate Army in Virginia, who, with unselfish devotion and rare skill, gave their time and talents to the care of the sick and wounded in hospitals and on the battlefield. Many were wounded, and some were killed whilst in the discharge of their duty. We append, however, in kindly and fraternal remembrance some data which may be of some service to the future historian of our Association, and for those who treasure the patriotism and surgical skill of the Medical Staff of the Confederate Army.

Dr. S. B. Moore, Surgeon General, made Richmond, Virginia, his home at the close of the war and there ended his life after an eventful and useful career, as medical officer in the United States and Confederate armies.

Dr. D. C. DeLeon, the first Surgeon General, C. S. A., after he was retired to private life, in his rural home in far-off New

Mexico, he also being a surgeon in two armies—the United States and Confederate Army, a genial gentleman and a patriotic Southerner.

Dr. Charles Bell Gibson, Surgeon in charge General Hospital No. 1, Richmond, was a son of Dr. Wm. Gibson, of Philadelphia. He resigned a professorship in a Baltimore College to accept one in the Medical College of Virginia at Richmond. A wonderfully handsome man and a great singer, he died in Richmond shortly after the war.

Dr. St. George Peachy was a native Virginian and a surgeon of great ability. He died a few years after the war. At this General Hospital No. 1, were Dr. Arthur E. Peticolas, a professor in the Medical College of Virginia, a noble man and an excellent surgeon. He died in Williamsburg, Va. Also Drs. Logan, of South Carolina; Tober, of Assbury, of same State; Dr. De Dossett, of North Carolina, Assistant Surgeon; Dr. Archer, of Maryland, Assistant Surgeon; Dr. Walker, of Virginia, Surgeon; Dr. Jones Berrien, of Georgia, a retired officer U. S. Army, resigned, was in this hospital for a short while, promoted to Surgeon of Virginia Cavalry Department, commanded for a short period by Colonel, afterwards General, Hood. He was one of the finest characters I met during the entire war. He, in latter days of the war, was Medical Purveyor for the Trans-Mississippi Department, headquarters in Texas; he was honored and beloved by every one in this State by his genial manners and the faithful discharge of his official duties. He died in Saltillo, Mexico, whilst in the practice of his profession. Dr. Cullen, Medical Director First Corps, Army of Northern Virginia, was born and died in Virginia. Dr. Hunter Holmes McGuire, Medical Director Second Corps, was born in Winchester, Virginia, was a son of Dr. Hugh McGuire, died last year. The oldest member of the medical profession now living in Richmond is Dr. James B. McCaw. He was once dean of the Medical College of Virginia (which was the only medical college in the South which did not suspend teaching during the war). Dr. McCaw was surgeon in charge of the Chimborazo Hospital during the war, where over 70,000 patients were treated during the four years.

We have already spoken of Dr. LaFayette Guild, one of the noblest men I ever knew, of his three years' service as Medical Director, Army Northern Virginia, and of his death in Oakland, California.

Dr. R. J. Breckinridge, of Kentucky, Inspector of Camps and Hospitals, Army Northern Virginia, a physician and surgeon of marked ability, died while in the practice of his profession in Houston, Texas.

Dr. J. H. Wingfield, of North Carolina, selected as the associate of Dr. Breckinridge, as Inspector on account of his great worth and ability, died after the war at Towsontown, Maryland.

Dr. W. H. Geddings, of Charleston South Carolina, Medical Purveyor, Army Northern Virginia, an accomplished physician and surgeon, died at Aiken, South Carolina.

Dr. J. C. Herndon, a typical Virginia gentleman and an excellent surgeon (resigned from U. S. Army), was a victim of yellow fever in Fernandina, Florida. Dr. Herndon was my associate surgeon under Dr. Guild.

Dr. Guild and all his immediate staff are dead. The writer is the only survivor.

Dr. Joseph E. Claggett, of Maryland, surgeon in charge of the Receiving and Forwarding Hospital, is the only survivor of his immediate staff, and is ending a life replete with kindness. He was a most valuable officer to the sick and wounded, Army Northern Virginia, as the transportation of same was his special duty.

Of his staff were Drs. S. H. Moffett, of Virginia; John De-Butts, of Maryland; Charles M. Hunter, of Virginia, and Dr. J. W. Sears, of Virginia, all able, earnest and faithful medical officers. — *Lost Cause.*

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## *Editorial.*

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### THE SEVENTY-FIRST ANNUAL MEETING OF THE TENNESSEE STATE MEDICAL ASSOCIATION.

THE approaching meeting of the State Medical Association at Chattanooga, April 12, 13, and 14 prox., should show a largely increased membership, and much of this increase should come from East Tennessee and the eastern counties of Middle Tennessee. A number of county societies have been organized since the Nashville meeting, and nearly all of these are in the middle division of the State. Meetings have been called recently in other counties, and, as the result of each call, a county organization will be effected. In several counties no call has been made,

so far as is known by the State committee, and unless the calls are issued soon it will not be possible for the profession in these counties to be represented in the meeting at Chattanooga. The committee had hoped that every county would answer the next roll call. The possibility of realization of this hope has not passed, but only a little time remains for doing the necessary work. Let a general call be issued at once in every county not already organized or in process of organization. To such a call surely three or more would respond, and those could adopt the model constitution and procure the charter. If composed of only three members, the society would be entitled to one representative in the House of Delegates, and all would be entitled to all the privileges of the House of Members and participation in the scientific work of the organization.

The other societies already organized should make an earnest and special appeal to the nonaffiliated members of the profession in their respective counties and thus add largely to the membership of one year ago. Do this and keep Tennessee from falling too far down the column in point of numbers. Will not officials send out these appeals at once? The time for this work is now less than two months.

The scientific work of the Chattanooga meeting promises much. The symposium on pneumonia alone will richly repay those who attend. The voluntary papers will be numerous and strong. Let every doctor in the State who reads this make his arrangements to attend. He who attends will return home enriched in thought and strengthened in purpose.

After the State meeting comes the Atlantic City meeting of the American Medical Association. One hundred physicians from Tennessee should attend. The second week in June could not be better spent.

The "Symposium on Pneumonia," which is made the special order for the morning of the second day's session, has been arranged as follows: "Etiology and Pathology," by Louis LeRoy, M.D.; "Symptomatology and Diagnosis," by John A. Witherspoon, M.D.; "Internal Treatment," by E. G. Wood, M.D.; "External or Topical Treatment," by E. A. Cobleigh, M.D.; "Bloodletting in Pneumonia," by John S. Cain, M.D.; "The Heart in Pneumonia," by J. B. Murfree, Jr., M.D.

The marked increase in the mortality of this disease in the recent past makes it of unusual importance, and the discussion that will follow the reading of the above papers will most certainly make a most attractive feature of the meeting. Among other papers that have already been promised, we take pleasure in mentioning the following: "Renal Surgery," by Richard Douglas, M.D., of Nashville; "Surgery of the Hand," by Paul F. Eve, M.D., of Nashville; "The Necessity of Visual Inspection of Railway Employees," by C. M. Capps, M.D., of Knoxville; "Brain Abscess," by W. A. Bryan, M.D., of Nashville; "The Surgical Treatment of Bright's Disease," by M. Goltman, M.D., of Memphis; "The Therapeu-

tic Treatment of Phthisis," by Rufus Pitts, M.D., of Murfreesboro; "Gastro-Enterotomy for the Cure of Intractable Dyspepsia," by W. D. Haggard, M.D., of Nashville; "Sanitary Advances," by E. H. Jones, M.D., of Murfreesboro; "Irrigation—Its Therapeutic Application," by E. P. Vaughan, M.D., of Manchester; "Study of the Leucocytes in Typhoid Fever," by William Litterer, of Nashville.

This brief list will be largely added to before the programme is completed, and is given at this early date to show the varied, interesting, and important character of the scientific features that may be expected at the meeting. Among other correspondence, which is increasing every day as the time of the meeting approaches, we publish the following from the very efficient chairman of the committee on arrangements, in response to a circular letter sent out to members of the Association:

*"My Dear Doctor Roberts:* I am glad to see that you are urging attendance of members upon the next meeting of the State Medical Association, for we at Chattanooga intend to arrange things for their comfort, and hope to have a 'record breaking' meeting in point of attendance.

"The Read House will be headquarters, and Mr. Read has placed the banquet hall of that hotel at our disposal for the general meetings, and the ballroom for the sessions of the House of Delegates. At these halls everything will be convenient and agreeable I am sure. I am looking after everything personally.

"The Read House is on the European plan, with rooms at from one dollar per day up. You can have your room there and take your meals elsewhere if you so desire; but the café and grill rooms are run in the best style and order. The Southern is on the American plan at two dollars to three dollars per day; the Stanton at two dollars and a half to four dollars per day, American plan, and one dollar and a half to four dollars per day European plan. The Rossmore, Russell, Northern, Almeda, are all small hotels, but neat, nice, and cheap.

"Concessions in the way of fare to the mountain and back will be given, also to Chickamauga Park, new army post, etc., for those who wish to visit these interesting and historic places.

"We have not and will not arrange anything to conflict with the meetings of the Association, yet our aim is to make all who come here have a most delightful and profitable time.

"Very truly and sincerely yours,

D. E. NELSON, M.D., *Chairman,*  
*Committee on Arrangements."*

In conclusion, we will state that correspondence has been taken up with the chairman of the Southeastern Passenger Association, and the usual reduced railroad rates may be confidently expected. In our next number we will be enabled to give further details, and write this that every one who may read it may make his arrangements, if possible, to take part in a most important and interesting meeting.



**POSTGRADUATE STUDY.**—Any of our friends who desire to avail themselves of most excellent opportunities of postgraduate work cannot do better than correspond at once with the New Orleans Polyclinic, P. O. Box 797, New Orleans, La. With a most excellent building, located at the corner of Liberty Street and Tulane Avenue (either belt line cars pass the door), with a most enterprising, courteous, and competent staff of teachers, and the splendid facilities of the immense charity and other hospitals and infirmaries in this great cosmopolitan metropolis of the South, with its teeming transient population, and a most enjoyable climate at this season, a few weeks spent here will be most enjoyable and profitable. Then again our Southern friends will find in the clinics here, just such a class of diseases and pathological conditions as most demand their attention, and the methods taught are just such as prove most applicable to the needs of our climate and section.

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**THE COCA PLANT.**—Coca is the leaf of an *Erythroxylon* shrub indigenous to equatorial America, employed during many hundred years, empirically, as a sustainer and restorer of muscular force. There are several varieties of coca, among which the aromatic or "sweet" leaf contains little if any cocaine, and is the only kind used by the natives. This is the classic coca to which phenomenal properties are ascribed. The "bitter" leaf, which they reject, is exclusively employed for cocaine extraction. Even since the popular introduction of cocaine, the natives will not use that alkaloid, which creates excitement without sustaining muscular power. Thus it is shown, even empirically, that the properties of true coca cannot be substituted by cocaine—a fact upon which all observers agree, but which is not yet generally recognized. Mariani, of Paris, was the first to introduce coca in available form; he recognized nearly half a century ago the great difference in coca leaves, and by a special blending of the sweet leaves, carefully treated in nutritious French wine, produced his unequalled neuromuscular stimulant, which, as a trustworthy preparation, has won high standing in the profession abroad and in this country by all practitioners who have subjected it to

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**BRONCHILINE** is indicated in bronchitis, coughs, laryngitis, pneumonia, asthma, and is a valuable remedy in the treatment of all irritable conditions of the respiratory tract. Efficient and agreeable. Contains no morphine, heroin, nor any form of opiates; gives prompt relief. Has been indorsed by leading physicians all over the United States for fifteen years. Formula furnished upon application. Prepared in sixteen-ounce bottle. Prescription price, \$1. A full-sized bottle sent to any physician, prepaid, upon receipt of fifty cents in stamps, to cover expressage. Neat-Richardson Drug Co., Louisville, Ky.



**SHADOW AND SUBSTANCE.**—Now that the cod-liver oil season is in full swing and the large and growing demand for this article made more apparent by the great scarcity of pure oil, the profession is better able to realize the position occupied by Scott's Emulsion. Every winter there is introduced at least one new cod-liver oil preparation, and until the following spring every inducement is made to unload it upon the public. This year has been no exception, despite the great scarcity of pure cod-liver oil. It is by reason of this latter condition that the profession should be careful what it recommends and uses in the way of cod-liver oil preparations that are not absolutely guaranteed. With cod-liver oil selling at unheard-of prices, the composition of some so-called emulsions, wines, extracts, etc., is likely to be far below the standard and comparatively worthless. It has been a great protection to the profession to know that Scott's Emulsion has maintained its position as the standard emulsion of cod-liver oil during this unsettled time and that its quality and purity have not been changed in the slightest particular. Its popularity has never been menaced or its usefulness superseded by any of the hundreds of imitations that have come and gone since Scott's Emulsion was first offered for sale. Its success is due to the fact that it is the substance and not the shadow of cod-liver oil.

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**THE COUGH-SEQUELA OF LA GRIPPE.**—Dr. John McCarty, of Briggs, Tex. (Louisville Medical College), in giving his personal experience with this condition, writes as follows: "Ten years ago I had la grippe severely and every winter since my cough has been almost intolerable. During January, 1902, I received a sample of antikamnia and heroin tablets and began taking them for my cough, which had distressed me all winter; and as they gave me prompt relief, I ordered an ounce box, which I have since taken with continued good results. Last fall I again ordered a supply of antikamnia and heroin tablets, and I have taken them regularly all winter, and have coughed but very little. I take one tablet every three or four hours, and they not only stop the cough, but make expectoration easy and satisfactory."

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**WAYNE'S DIURETIC ELIXIR** is the best and safest in the treatment of urinary calculus, gout, rheumatism, Bright's disease, diabetes, cystitis, hematuria, albuminuria, and vesical irritations generally. Dr. Charles Kelly Gardner, of West Virginia, in a recent letter, writes: "I anticipate as positive results when administering it as I do from opium for pain or quinine for intermittents." It has been in constant use by the best physicians for twenty-two years. Try it, doctor. Allow no substitution, for there is nothing "just as good."

**ANTIDIPSOLE** is an ethical remedy for the treatment of the whisky habit. Heartily indorsed by the leading physicians of this city. The countless testimonials we receive from physicians all over the United States enable us to assure you that Antidipsole will give satisfaction in cases of chronic alcoholism. Write for booklet containing formula and testimonials from leading physicians. If your druggist cannot supply you, we will send the medicine to your address, express charges prepaid, on receipt of \$2. Neat-Richardson Drug Co., Louisville, Ky.

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**NEW ORLEANS POLYCLINIC.**—Sixteenth annual session opens November 2, 1903, and closes May 28, 1904.

Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory work.

For further information, address New Orleans Polyclinic, P. O. Box 797, New Orleans, La.

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RECEIVED SAMPLE OF ECTHOL and have used same on a bad case of follicular tonsillitis with a complete cure in twelve hours. This is certainly remarkable, and am very much pleased with it. At present time am using it on a leg ulcer with remarkable results, and can heartily recommend it to the profession.

H. B. HANNON, M.D.

*Chicago, Ill.*

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**MEETING OF THE BOARD OF MEDICAL EXAMINERS FOR THE STATE OF TEXAS.**—The next meeting of the Board of Medical Examiners for the State of Texas (Regular) to examine applicants to practice medicine, surgery, midwifery in that State will be held in Austin, Tex., April 21, 22, and 23, 1904. For further information, address Dr. M. M. Smith, Secretary, Austin, Tex.

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**A MOST EXCELLENT OPPORTUNITY.**—Our esteemed friend Dr. Q. Cincinnati Smith, 617 Colorado Street, Austin, Tex., desires for personal reasons, after living and practicing in Austin for more than a quarter of a century, to move to California. He offers his residence for sale at the cash price of \$3,000. It is a most excellent opportunity for any one desiring to secure a practice in the capital city of Texas. He will give all possible aid in securing his clientele to a suitable purchaser. Write to him.

## *Reviews and Book Notices.*

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**A MANUAL OF MEDICINE.** Edited by W. H. Allchin, M.D., London, F. R.C.P., F.R.S., Editor Senior Physician and Lecturer on Clinical Medicine, Westminster Hospital; Examiner in Medicine, Naval Medical Service; Examiner in Medicine in the University of London; for the Royal College of Physicians, London, etc. Part V., Diseases of the Digestive System and Liver, Peritoneum, Vessels of the Abdomen, Kidneys, and Ductless Glands. 8 vo., cloth; price, \$2.00. The Macmillan Co., New York and London, publishers. 1904.

The fifth volume of this most excellent manual is fully up with the high order of its predecessors. The important subjects considered in this volume are the digestive system, the liver, peritoneum, abdominal vessels, the kidneys, and the ductless glands. As a work of reference, and for the use of the general practitioner it will prove most valuable. The handy size of the volume makes it very convenient. Quite a number of illustrations add to its many other excellencies.

**INTERNATIONAL CLINICS.** A Quarterly of Illustrated Clinical Lectures, and especially prepared articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pediatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose and Throat, and other Topics of Interest to Students and Practitioners by leading Members of the Medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, with the collaboration of Drs. Wm. Osler, of Baltimore; Jno H. Musser, M.D., of Philadelphia; James Stewart, M.D., of Montreal; J. B. Murphy, M.D., of Chicago; A. McPhedran, M.D., of Toronto; Thos. M. Rotch, M.D., of Boston; J. W. Balantyne, M.D., of Edinburgh; Edmund Landolt, M.D., of Paris, and others, with regular correspondents in the larger cities of the world. Vol. IV., Thirteenth Series, 1904. 8vo., cloth; 321 pages. Price, \$2.00 net. J. B. Lippincott Co., Publishers, Philadelphia. 1904.

This valuable series of Clinical Articles is worthy of the highest commendation, and the continued success it has obtained is a correct criterion of its just merits. This success, made possible by the continued support of the medical profession, is unquestionably due to the very practical nature of the work and its eminent editorial corps. The special articles

by such men as Senn, DaCosta, Duckworth, Tyson, Musser, McFarland, Casey Wood and others so prominent in their various lines, make it of more than ordinary value. In no particular does this fourth volume of the thirteenth series fall behind any of its predecessors.

**THE ADVERTISER'S HANDY GUIDE, VOLUME XVI.**

Has just been issued by the Lyman D. Morse Advertising Agency, whose reputation in the advertising field is world wide. It is a standard work of reference, indispensable to advertisers large and small, and as important to the buyer of space as a "price current" is to a buyer of goods. If any evidence were needed that this work has permanently taken the lead in its class, it will be found in the fact that the Lyman D. Morse Advertising Agency has received a very large number of commendatory letters from the leading advertisers in both the United States and Europe.

Not the least of its important features is its condensed form. It may be carried with ease in the pocket, and as such commends itself to every traveling salesman, who contracts for advertising in the towns along his route. Its up-to-date character is shown by the addition of a list of publications in Cuba, West Indies, Mexico, Central America and South America. In addition to this and the general list of Daily and Weekly newspapers, are special lists of class publications grouped under the following heads: Magazines, Medical Journals, Agricultural and Religious papers and those in foreign languages.

It may be obtained from the publishers—Lyman D. Morse Advertising Agency, 38 Park Row, New York, on receipt of the price, \$2.00.

**THE RELATION OF SOCIAL DISEASES AND MARRIAGE.** By Prince A. Morrow, A.M., M.D., Emeritus Professor of Genito-Urinary Diseases in the University and Bellevue Hospital Medical College; Surgeon to the City Hospital; Consulting Dermatologist to St. Vincent's Hospital, etc., New York. In one very handsome octavo volume of 390 pages. Cloth, \$3.00 net. Lea Bros. & Co., Publishers, Philadelphia and New York. 1904.

It is the object of this work to set forth clearly the dangers introduced by venereal diseases into marriage—dangers to the wife, dangers to the offspring, and dangers which come from

their morbid irradiations into family and social life—and to indicate the most effective means to prevent these dangers or to limit and circumscribe their spread. This protective duty, which has for its object the preservation of the helpless and innocent from infection, devolves upon the physician in his capacity as sanitarian and guardian of the public health. The fulfillment of this duty realizes the highest ideals of preventive medicine. In safeguarding marriage from the dangers of venereal diseases, the physician becomes the protector of the wife and mother and the preserver of future citizens to the State.

The situations created by the introduction of venereal diseases in marriage are many and complicated; the problems presented are delicate, perplexing, and difficult of solution. In dealing with these situations there is required not only a thorough knowledge of these diseases in all their relations, but also a knowledge of human nature, a professional sagacity and a savoir-faire, which are not taught in the curricula of our medical schools.

It is the purpose of this study to indicate the general principles which should form the basis of the physician's conduct and to formulate as definitely as possible rules for his guidance in dealing with the various situations which may present themselves in practice.

**THE BLUES (SPLANCHNIC NEURASTHENIA) ; CAUSES AND CURE.** By Albert Abrams, A.M., M.D., (Heidelberg), F.R.M.S., Consulting Physician Denver National Hospital for Consumptives, the Mount Zion and the French Hospitals, San Francisco; President of the Emanuel Sisterhood Polyclinic; formerly Professor of Pathology and Director of the Medical Clinic, Cooper Medical College, San Francisco. 8vo., cloth; 240 pages; illustrated. Postpaid, \$1.50. E. B. Treat & Co., Publishers, 241-243 W. 23rd Street, New York.

The object of this volume is to direct attention to a new and heretofore undescribed variety of nerve exhaustion, which I have designated as Splanchnic Neurasthenia. This special form of nerve weakness is characterized by paroxysms of depression of varying duration, and is popularly known as "the blues." Its recognition is of more than theoretic interest. A mere theory may be of interest to our profession, but the layman asks science for results.

Its recognition, and the factors involved in its causation, imply our ability to cope with the evil and to offer to the sufferers not only amelioration, but a cure.

Among the many resources of Nature to combat this tendency, the vigor of the abdominal muscles is paramount. The tonicity of the muscles in question is impaired by mal-hygienic clothing, occupation, disease, lack of exercise, and a host of other conditions. The decadence of the abdominal muscles is a modern heritage; and so are hemorrhoids, constipation, hernia, and a multitude of other evils that may be traced to enfeebled abdominal muscles.

**THE TREATMENT OF FRACTURES. WITH NOTES UPON A FEW COMMON DISLOCATIONS.** By Chas. L. Scudder, M.D., Surgeon to the Massachusetts General Hospital. Fourth edition; thoroughly revised, enlarged and reset. Octavo volume of 534 pages, with nearly 700 original illustrations. Philadelphia, New York, London. W. B. Saunders & Company. 1903. Polished buckram, \$5.00 net; Sheep or half morocco, \$6.00 net.

Four large editions of this work in less than four years testify to its value. The book is intended to serve as a guide to the practitioner and student in the treatment of fractures of bones. The student sees the actual conditions as they exist in fractured bones, and is encouraged to determine for himself how to meet the conditions found in each individual case. Methods of treatment are described in minute detail, and the reader is not only told, but is shown how to apply apparatus, for as far as possible, all the details are illustrated. This elaborate and complete series of illustrations constitutes a feature of the book. There are 688 of them, all from new and original drawings and reproduced in the highest style of art. Several chapters of special importance are those on Gunshot Fractures of Bone; The Rontgen Rays and Its Relation to Fractures; The Employment of Plaster-of-Paris, and the Ambulatory Treatment of Fractures.

In this fourth edition many new illustrations have been added, thus increasing the accuracy of this part of the work. The text has been thoroughly revised, thereby bringing the book absolutely abreast the times. X-ray plates of the epiphyses at different ages have been arranged. These will be found of value not only as an anatomical study but in the appreciation of epiphyseal lesions. An important addition is

that of a chapter upon a few common dislocations. This chapter, like the rest of the book, is amply illustrated, and the accepted methods of treatment described.

**A TEXT-BOOK OF LEGAL MEDICINE AND TOXICOLOGY.** Edited by Frederick Peterson, M.D., Chief of Clinic, Nervous Department of the College of Physicians and Surgeons, New York; and Walter S. Haines, M.D., Professor of Chemistry, Pharmacy, and Toxicology, Rush Medical College, in affiliation with the University of Chicago. Two imperial octavo volumes of about 750 pages each, fully illustrated. Philadelphia, New York, London. W. B. Saunders & Company, 1903. Per volume, cloth, \$5.00 net; Sheep or half morocco, \$6.00 net.

This work presents to the medical and legal professions a comprehensive survey of forensic medicine and toxicology in moderate compass.

For convenience of reference the treatise has been divided into two sections, Part I and Part II, the latter being devoted to Toxicology and all other portions of Legal Medicine in which laboratory investigation is an essential feature. Under "Expert Evidence" not only is advice given to medical experts, but suggestions are also made to attorneys as to the best methods of obtaining the desired information from the witness. The Bertillon and Greenleaf-Smart systems of identification are concisely and intelligently described, and the advantages of each stated. An interesting and important chapter is that on "The Destruction and Attempted Destruction of the Human Body by Fire and Chemicals;" for on the determination of the human or animal source of the remains frequently depends the legal conduct of a given case, and the guilt or innocence of the accused. A chapter not usually found in works on Legal Medicine, though of far more than passing significance to both the medical expert and the attorney, is that on the medicolegal relations of the X-Rays. The responsibility of pharmacists in the compounding of prescriptions, in the selling of poisons, in substituting drugs other than those prescribed, etc., furnishes a chapter of the greatest interest to everyone concerned with questions of medical jurisprudence. Also included in the work is the enumeration of the laws of the various States relating to the commitment and retention of the insane. In fact, the entire work is overflowing with matters of the utmost importance, and expresses clearly, concisely, and accurately the very latest opinions on all branches of forensic medicine and toxicology.



**THE SELF-CURE OF CONSUMPTION WITHOUT MEDICINE**, with a chapter on the Prevention of Consumption and Other Diseases. By Chas. H. Stanley Davis, M.D., Ph.D., Member of the Connecticut State Medical Society; Author of Training and Education of Feeble-minded, Idiotic, and Imbecile Children, etc. 8 vo., cloth. Price, 75 cents. E. B. Treat & Co., 241-243 W. 23rd Street, New York, Publishers. 1904.

Consumption is the most widespread of all diseases, as shown by the statistics of the various boards of health. The object of this little work is to show how from its beginning to its last stages, before actual decay of the lung takes place, it can be cured in at least 95 per cent. of the cases, and this without the use of medicine.

**ORGANIC AND PHYSIOLOGICAL CHEMISTRY.** (The Medical Epitome Series). A Manual for Students and Practitioners. By Alexius McGlannan, M.D., Associate Professor of Physiologic Chemistry and Instructor in Chemical Laboratory, College of Physicians and Surgeons, Baltimore; and edited by V. C. Pedersen, A.M., M.D., Instructor in Surgery and Anesthesia and Anesthetist at the New York Polyclinic Medical School and Hospital. Cloth; 246 pages; illustrated; Lea Bros. & Co., Publishers, New York and Philadelphia. 1904.

The purpose of this little manual is to select from the great mass of knowledge accumulated in its department such facts as are of essential importance to medical students and practitioners, and to present them in a style facilitating comprehension and retention. Brevity and clearness have necessitated plain and dogmatic statements, even though several different theories co-exist. This being particularly true as to physiological chemistry, however, in such cases, the most generally accepted hypothesis is given without comment. A number of leading, comprehensive and practical questions conclude the chapters.

**THE PRACTICAL CARE OF THE BABY.** By Theron Wendell Kilmer, M.D., Associate Professor of Diseases of Children in the New York School of Clinical Medicine; Assistant Physician to the Out-Patient Department of the Babies' Hospital, New York; Attending Physician to the Children's Department of the West Side German Dispensary, New York. 12 mo. Pages xiv-158, with 68 illustrations; extra cloth, \$1.00 net, delivered. Philadelphia, F. A. Davis Company, 1914-16 Cherry Street, Publishers.

The author states in his preface that in writing this book "he has regarded the mother and nurse as knowing absolutely nothing about the care of the baby," consequently, he has gone

considerably into detail. His views are eminently practical, and will prove of value to even those who think they know something about babies. It is appropriately illustrated, intelligent to mothers and nurses, as well as to physicians, and will be found useful to all.

**FISCHER — INFANT-FEEDING IN ITS RELATION TO HEALTH AND DISEASE.**

A Modern Book on all Methods of Feeding. For Students, Practitioners, and Nurses. By Louis Fischer, M.D., Visiting Physician to the Willard Parker and Riverside Hospitals, of New York City; Attending Physician to the Children's Service of the New York German Poliklinik; Former Instructor in Diseases of Children at the New York Post-Graduate Medical School and Hospital; Fellow of the New York Academy of Medicine, etc. Third edition; thoroughly revised and largely rewritten; containing 54 illustrations, with 24 charts and tables, mostly original; 357 pages,  $5\frac{3}{4} \times 8\frac{3}{4}$  inches. Neatly bound in extra cloth. Price, \$1.50 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This work intended as a guide to the active practitioner as well as the student of medicine has undergone a thorough, complete and careful revision. A great many chapters have been changed, some new ones, including one on "Infant Feeding in Summer Complaint," have been added. A new diet for older children after weaning from the breast or bottle, has also been added. The preceding edition has received the most gratifying and complimentary mention by a large number of the leading medical journals. Many suggestions which have been offered for improving the practical value of the book have been carefully considered, and numerous important and valuable additions have been made. In the short space of six months, a second edition has been demanded.

**THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY FOR 1904.** A Yearly Digest of Scientific Progress and Authoritative Opinion in all branches of Medicine and Surgery, drawn from journals, monographs, and text-books of the leading American and foreign authors and investigators. Arranged, with critical editorial comments, by eminent American specialists, under the editorial charge of George M. Gould, A.M., M.D. In two volumes. Volume I, including *General Medicine*. Octavo, 673 pages, fully illustrated; Volume II, *General Surgery*. Octavo, 680 pages, fully illustrated. Philadelphia, New York, London. W. B. Saunders & Co., 1904. Per volume: Cloth, \$3.00 net; Half Morocco, \$3.75 net.

The American Year-Book of Medicine and Surgery continues to maintain its high place among works of its class. Indeed,

the issue of 1904, now before us, if anything, is even better than the excellent issues of previous years. Such a distinguished corps of collaborators which the editor, Dr. George M. Gould, has enlisted as his assistants is sufficient guarantee that the essential points of progress are brought out, and the collaborators' notes and commentations are excellent. In the illustrative feature the 1904 issue fully maintains its reputation, there being fourteen full-page insert plates, besides a number of excellent text-cuts. We pronounce Saunders' Year-Book for 1904 the best work of its kind on the market, as it has always been.

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## *Selections.*

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*Dysmenorrhœa and Sterility.\**—Dysmenorrhœa and sterility are, perhaps, two of the most common complaints for which women seek for medical advice. When these symptoms exist separately, they may be due to many causes; when they are associated, they result most frequently, I believe, from a congenital or a traumatic constriction of the canal of the cervix uteri. However acquired, there is thereby produced a definite mechanical obstacle to the egress of menstrual blood and the ingress of seminal fluid.

All gynaecologists have seen examples of what I may term traumatic stenosis; where after a difficult labor the woman has, perhaps for the first time, commenced to have severe menstrual pain and has not conceived again; and where on examination we find a hard cervix with small contracted orifice, and inspection shows dense cicatricial tissue where labor had evidently lacerated the cervical lips. These cases are equally amenable, I find, to the treatment I am about to describe; but as they are comparatively rare I will restrict what I have to say to the more common or congenital form of stenosis of the cervix. And, as that condition is relative—the narrowing being much more marked in some cases than in others—I would again contract the field by explaining that I

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\*A paper read before the British Gynæcological Society on Dec. 10, 1903, by Richard Fenwick, M.D., Physician to the Hospital for Women, Soho Square, London.

will chiefly refer to the condition known to us all as a "conical cervix." It is, in fact, abnormally long, often measuring an inch to an inch and a half or even more. It tapers downward, and therefore the external orifice is almost invariably so small that it is described in the older text-books as the "pinhole os." This is, in fact, so contracted that it is often impossible to pass an ordinary uterine sound through the opening, and when a surgical probe is introduced it is found to be tightly gripped along the whole length of the cervical canal. With regard to the dysmenorrhoea in these cases, this almost invariably begins one or two hours before the menstrual flow is observed, and becomes gradually worse until the loss is established. It is often associated with clotting of the menstrual blood, and the passage of each clot through the contracted canal causes exacerbation of the pain. Although certain distinguished writers have denied that the pain is due to obstruction, I must confess that, to my mind, the mechanical cause of the dysmenorrhoea appears to be self-evident. When one remembers that behind the contracted cervix there is a distensile cavity in the shape of the uterine canal, and great propulsive power in the shape of the uterine walls, surely it requires equally little knowledge of physics or of physiology to realize that pain must be experienced at the point where there is sufficient obstruction to cause uterine contractions to secure the passage of the uterine contents. This natural effort at distension of a closed canal is accepted, indeed, as an obvious explanation of the pains in the first stage of labor; so that it is difficult to understand the grounds upon which the mechanical theory is disputed in these cases of cervical stenosis.

Passing, however, from theory to practice, I would first call attention to the historical fact that for nearly fifty years operative treatment of some kind or other has been employed to remove this contraction of the cervical canal, in the hope of curing the associated menstrual pain. Half a century ago, it was the custom to pass a bistoury up the cervical canal and incise what is called in the text-books the internal os. In the great majority of the cases so treated, the benefit, if any, was found to be entirely temporary; and the operation fell into disuse; the more so because in not a few patients such extreme and furious hemorrhage occurred—probably from the opening of some branch of the uterine artery—that they narrowly escaped with their lives. Then came the method of introduc-

ing tents of compressed sponge, laminaria, and so forth, which caused dilatation of the canal, but, of course, extreme and continuous pain; and in not a few cases septic absorption was followed by pelvic cellulitis. At the best, the dilatation was never permanent, and in due course that treatment also fell into disfavor. Then came the more modern, and certainly more cleanly, treatment by glass and galvanic stems, solid or hollow, which were worn for weeks by the patient, and which certainly, in some instances, resulted in permanent softening and dilatation of the cervical canal. But, on the other hand, the constant irritation and pressure often induced inflammatory troubles in the uterus or in its surrounding cellular tissue; so that, I suppose, at the present day, this treatment is rarely adopted. Finally, there came into vogue the practice of dilating the contracted canal by means of graduated metal sounds; and, in patients who were averse to any more radical operation, there can be no doubt that the passage of three or four of these sounds—Numbers 6, 7, 8 and 9 being usually employed—and their retention for some ten minutes, resulted in a temporary dilatation, and, when the procedure was adopted just before the menstrual period, the pain was often alleviated. Unfortunately, however, such dilatation is, of course, quite temporary in its duration. The constant tendency of the tissues is to contract at once, and therefore the treatment must be repeated again and again. This fact led to a modification of the old cutting operation; the lips of the cervix were incised on both sides for a certain distance up the canal. The great difficulty always met with is that, performed with antiseptic precautions, there is left a perfectly clean cut, the lips of which naturally fall together at once, and the upper angles of which immediately unite. To prevent this rapid union, many methods have been tried. The divided lips were plugged, but the result of the irritation, of course, was to keep up granulation, and the moment the plug was removed those granulations fell together and immediately coalesced. Caustics were applied to the cut surfaces to prevent their immediate union, but the only effect of these is to stimulate the growth of granulation tissue, and, once again, to cause sooner or later the growing together of the severed surfaces. In short, whatever method was adopted, the result in nine cases out of ten was that in six months, or perhaps less, the severed lips of the cervix had reunited. And not only was the canal again con-

tracted, but, as the new tissue was thicker and cicatricial, the degree of contraction was often greater, and the resistance of the cervical tissue to expansion was increased; so that the latter condition of that patient was probably worse than the first. Still, it occasionally happened that the lips healed separately and apart, leaving a perfectly patent cervix; and the relief experienced by such patients was so great and so permanent that it not only established the usefulness and the scientific advisability of treatment by incision, but it prevented the method from falling entirely into disrepute and disuse. Some years ago, a succession of patients, of some social importance, suffering from dysmenorrhoea and sterility led me to study the subject somewhat carefully. The clinical facts, to which I have briefly alluded, seemed to point conclusively, not only to the mechanical nature of the obstruction in these cases, but also to the obvious argument that the patients could only be cured by removing that obstruction. One remembered how commonly lacerations of the cervix occur during labor, and how these, in most cases, close up completely; while in others the lips remain widely separated, and heal in that condition. Further thought and inquiry led me to find that the former cases occurred most frequently when the patient was in perfect health, and had received the best possible surgical and nursing care; when there was comparatively little discharge from the uterus, and when douches were so regularly employed as to keep the entire genital tract, and especially the wounded surface of the cervix, in a surgically clean condition. On the other hand, I found that the widely separated lacerations of the cervix were very common among hospital out-patients, where the uterine discharges had been by no means aseptic, where the patient's health was depreciated, where cleanliness, in fact, was too often only conspicuous by its absence. In fact, whenever there is an unhealthy discharge from the uterus after the lips of the cervix have been torn, as one might almost expect, the wounds bathed with this discharge will not unite, but will separately heal. It was, therefore, plain that in the case of a surgical aseptic wound nature would give no assistance in keeping the edges of the wound apart, but would devote all her efforts to drawing them again together in order to repair the injury which surgery had caused.

It therefore seemed to me that the only possible method of preventing immediate adhesion between the incised cervical lips was to draw one entirely apart from the other whilst healing process was going on. I first attempted to effect this by means of a catgut stitch passed through the tip of the anterior lip and then higher up on the anterior vaginal wall, a similar stitch being passed through the posterior lip and the posterior vaginal wall, so that when these were tied the lips were dragged apart. But, after a few days, the catgut softened, the lips fell together again and united in the ordinary manner; and so I adopted, and have now for some years practiced, the following method, which is simple, surgical, and has proved to be perfectly effective.

I had not previously heard of the operation being done by anyone else, but I have shown it now for some years at The Hospital for Women, and am glad to hear that it has proved equally successful in other hands.

The patient being anaesthetised and in the lithotomy position, the vagina is well douched and cleansed. The posterior wall of the vagina is retracted by a weighted speculum, a double hook is passed through the anterior lip of the os, and the cervix is drawn down. The cervical canal is then dilated by graduated metal sounds up to No. 16 or 16½; one blade of the scissors is then passed half way up the cervical canal—that is to say, in many of these cases of conical cervix, from half to three-quarters of an inch—and an incision is made to that extent on each side; the posterior lip falls back, the anterior lip is drawn forward with the hook. A small needle threaded with strong catgut is passed through the left side of the anterior lip close to the upper angle of the incision, and then across and through the corresponding point on the right side. The catgut is cut sufficiently short, and a similar stitch is inserted about midway between the former and the tip of the cervix. The anterior lip is sponged clean of blood, and, first the upper, and then the lower, stitch is tied. The result, of course, is that the anterior lip of the cervix is indrawn together; the raw surface being closed completely, whilst the posterior lip is left flat and open. Two or three wool plugs are then applied tightly against the cervix to check hemorrhage. These are removed in about sixteen hours, and then it is found that the posterior lip is glazed over with lymph and quite dry. In about a week, it is covered with mucous membrane extend-



ing up to the angle of the wound. Meanwhile, the catgut in the anterior lip is gradually softening, and, as a general rule, the wound gapes open, while at the same time it is becoming glazed over with mucous membrane. At the end of ten days, I cut the catgut stitches and remove them, and then the anterior lip flattens out and lies nearly in its normal position, but with this difference—that both the apposed surfaces being covered with mucous membrane they cannot adhere together; and on passing the finger one finds that the cervix is widely patent. As a rule, there is no discharge, and at the end of a fortnight the patient is able to resume her home life.

For the purpose of this paper, I have looked up my notes of all the hospital and private cases I could remember for whom I have performed this operation. They amount altogether to eighty-seven cases. In every case, my notes show that the first period after the operation was practically free from pain. In twenty-eight of the cases, I have a note of the patient at the end of two years, and in every one of those cases the relief had been permanent for that time. In another thirty-three cases my notes only extend to an average of eleven months after operation, and in each of those the relief was equally definite. Of the remaining cases, in ten I can only find a note for three or four months after the operation, but in those again the relief so far had been permanent. In eight cases, varying from four months to two years, some amount of menstrual pain had returned, but in each case to a much less degree than had been formerly experienced. In the remaining eight cases, I have no note after the first month; but, as I have asked every patient for whom I have done this operation to write to me if she had any return of her previous symptoms, and as I have not heard at all from these eight cases, I think I am almost justified in thinking that they have also been permanently relieved, and that therefore I am well within the mark in estimating that of the patients with dysmenorrhoea from conical cervix for whom I have performed this operation, in 91 per cent. the relief from pain has been complete and permanent.

With regard to sterility, I find that out of the eighty-seven cases forty-one were sterile, having been married for periods varying from two to eleven years. I have heard, so far, from twenty-four of these cases, in eighteen of whom pregnancy has resulted after an average sterility of five and a half years.

On the whole, therefore, I think I am justified in saying that, in these cases of conical cervix, both the dysmenorrhoea and the sterility are directly due to the contraction and lengthening of the cervical canal, and consequently to mechanical obstruction; that the latter can be completely removed by incision of the cervix, provided that the incision can be kept permanently patent; and that, by the method I have described, which I submit is surgically sound, such patency can be secured; and, finally, that the actual results in practice are sufficiently good to warrant a more extended trial of the operation.—*Medical Times and Hospital Gazette, London.*

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INTERNATIONAL QUARANTINE BUREAU,—The following communication from the International Quarantine Bureau, issued Jan. 1, 1904, by the President, Dr. J. McG. Lindsley, discusses a subject of the greatest importance to all physicians, and particularly to those of the Southern States:

“Quarantine regulations against yellow fever must be based upon the demonstrated fact that yellow fever is transmitted only by the mosquito. In our previous letters we have shown that the great preponderance of testimony on the part of physicians and scientists who have made a special study of yellow fever agrees that it is transmitted in nature only by the mosquito. Since our last letter, in the annual meeting of the American Public Health Association, not one objected to this doctrine, and Dr. J. Y. Porter, Health Officer of Florida, said he accepted it in toto. So practically the only quarantine authorities not on record as accepting this doctrine are these: Surgeon General Wyman, of the Public Health and Marine Hospital Service, President of the Louisiana State Board of Health, and Dr. Tabor, Health Officer of Texas. With the bitter experience of Dr. Tabor in fighting yellow fever in Texas, without taking the mosquito into account, he will be open to new light on the subject.

“Last spring in a conversation which I had with Dr. Tabor in the St. Charles Hotel, New Orleans, before his visit to Havana, he ridiculed the idea of the mosquito being the only natural means of transmitting yellow fever, and would not agree to regulate quarantine upon that basis, stating to me that the Governor of Texas had told him if he let yellow fever into Texas he would ask for his resignation. Dr. Tabor has been a

bitter foe to scientific quarantine, based upon the mosquito theory, and as he has had the whole matter in his own hands in Texas, and has the commercial interests of New Orleans and other Southern cities at his mercy, they will do well to remember his attitude and protect themselves against a repetition of the mistake.

"Dr. Roux tells me Pasteur Institute Commission has absolutely settled upon the mosquito as the sole agent for the dissemination of yellow fever."—Dispatch from Dr. Giddings, of Public Health Service.

Following this are indorsements from the Army and Navy Departments, extracts from reports of Reed and Carroll, of the Yellow Fever Commission, and the remarks of Doty, Health Officer of the Port of New York, and Dr. Juan Guiteras, the celebrated yellow fever expert. It is regretted that lack of space does not allow us a full publication of this interesting document.—*Cincinnati Lancet-Clinic*.

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THE PATHOLOGY AND SURGICAL TREATMENT OF BRIGHT'S DISEASE.—S. C. Gordon (*Annals of Gynecology and Pediatrics*, November, 1903) says that Bright's disease is primarily an acute inflammation of the kidney structure, not dependent upon any specific infective germ, which if early recognized and properly treated will terminate by resolution. If neglected or not recognized, repeated acute attacks may occur, each one leaving products of the inflammatory process, which may organize or even suppurate. Acute attacks are always short, but leave more or less products, which interfere with the circulation, finally producing a chronic passive congestion incorrectly called "chronic inflammation." The result of these attacks is an enlargement of the organs, causing pressure of the fibrous capsule. Complete decapsulation relieves this pressure, depletes the distended vessels by more or less bleeding, and allows the circulation to resume its normal condition and absorb the exudate. Even one kidney alone may be involved, and the symptom be relieved by operation upon that one only. The surgeon may be justified in operating even in cases far advanced when the suffering is great, simply for relief of the suffering.—*Medical Age*.

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R. Spts. chloroformi..... $\mathfrak{z}$  i  
Syrupis ..... $\mathfrak{z}$  i  
Aquaë ..... $\mathfrak{z}$  iv

M. Sig.: Two tablespoonfuls to be taken every hour until the entire amount is taken. Before the last dose, a purgative dose of castor oil or tincture of jalap is prescribed.

S. P. Gerhard, in *Medical Record*, recommends in the removal of tapeworm a combination of male fern and pelletierine as the most suitable remedy. The patient is instructed to take a good cathartic such as castor oil or salts the day previous to taking the teniafuge. The following morning, as early as possible, a dose of pelletierine tannate, grains 20 (1.30), is taken in two capsules at one dose. When this has operated freely, in about two hours, the following treatment is begun:

R. Oleires. aspidii  
Spts. etheris,  $\bar{a}$   $\bar{a}$ ..... $\mathfrak{z}$  ii  
Hydrarg. chloridi mitis.....gr. xii

M. Ft. cap. No. xvi. Sig.: Two every ten minutes. No food should be taken during this treatment, and the worm will be passed in the course of two or three hours.

### URTICARIA.

R. Potass. Carbon.....gr. x.  
Aquaë .....oz. iv.  
M. S.: Teaspoonful every hour.

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## PNEUMONIA.

The following combination is recommended by *Medical Review of Reviews* in the treatment of pneumonia in the early stage, occurring in children:

R. Potassii citratis.....℥iiss  
Spts. etheris nitrosi.....℥vi  
Liq. ammon, acetatis.....℥i  
Syr. tolutani  
Aquæ, ā ā q. s. ad.....℥iv

M. Sig.: One dessert-spoonful every three hours to a child of three years.

During the stage of expectoration the following combination is recommended for a child of the same age:

R. Ammon. carb.....gr. xlvi  
Ammon. iodidi.....gr. xxiv  
Syr. tolutani  
Syr. acaciæ, ā ā q. s. ad.....℥iii

M. Sig.: One teaspoonful every two or three hours.

## INHALATIONS OF FORMALIN.

Spengler, in *Boston Medical and Surgical Journal*, recommends formalin inhalations in pulmonary tuberculosis and fetid bronchitis prepared after the following formula:

R. Formalin.....m. lxxv  
Alcoholis (absolute).....℥v  
Spts. etheris.....℥iiss

M. Sig.: Place ten drops in a tumbler and take ten or twelve deep inspirations, the mouth being removed from the glass to exhale. The first inhalations should be superficial and the latter ones deep. Inhalations are made every other day at bedtime, and stopped after two weeks, to be resumed in a few days and continued as before.

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 Aq. Rosae.....aa dr. iiss.  
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### Morphine Ointment:—

R. Morphin Hydrochlor.....gr. viij.  
 Lanolin.....dr. iiss.

### Iodine Ointment:—

R. Potass. Iodid.....gr. xxx.  
 Iodin .....gr. iss.  
 Ung. Emoll.....dr. v.

M.

### Ichthyol Ointment:—

R. Ichthyol.....gr. xv.  
 Lanolin .....dr. iiss.

M.

### Precipitate Ointment:—

R. Hydrarg. Praecip. Alb.....gr. xv.  
 Ung. Petrol.....dr. iiss.

M.

### Diachylon Ointment of Hebra:—

R. Emplas. Litharg. Simp.....  
 Ol. Olivae.....aa oz. j.

M.

### Chrysarobin Ointment:—

R. Chrysarobin.....dr. j.  
 Lanolin .....oz. j.

M.

### Camphor Ointment:—

R. Camphor. Pulv.....gr. xlv.  
 Ung. Petrolat.....oz. j.

M.

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## PRURITUS OF THE SCROTUM.

R. Hydrarg. Bichlorid.....gr. viij.  
 Alcohol .....  
 Aquae Chamomil.....aa dr. vj.  
 Chloroformi .....gtt. v.  
 Aquae Camphor.....q. s. ad. oz. iij.

M. S. Apply as lotion.

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R. Chloroform.....oz. j.  
Essence of Cloves.....m lxxv.-dr. v.  
Creosote .....m xv-xxx.  
Camphorated Oil.....oz. ij.

Mix. For external use only.

R. Salicylate of Mercury.....gr. ij-v.  
Salicylic Acid.....gr. xv-xxx.  
Rectified Spirits.....oz. ss-j.  
Distilled Water.....ad oz. iv.

Mix. For external use only.

The affected part is covered with compresses saturated with either of the above antiseptic mixtures. At the same time, one or other of the following solutions is injected into the boil or carbuncle:—

R. Carbolic Acid.....gr. j-ij.  
Salicylate of Sodium.....  
Borax.....aa gr. xv.  
Glycerin .....m xxx.  
Chloroform Water.....dr. ij.

F. S. A.

R. Iodoform.....gr. v-vij.  
Salol.....gr. viii.-xv.  
Carbolic Acid.....gr. iss.  
Ether.....dr. ss-j.  
Rectified Spirits.....dr. iss-ij.

F. S. A.

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### *Original Communications.*

#### CANCER OF THE UTERUS AND THE PHYSICIAN'S DUTY. \*

BY M. C. McCANNON, M.D., OF NASHVILLE, TENN.,

Professor of Diseases of Women and Abdominal Surgery in the Med. Dept. of  
the University of Nashville, Gynecologist to the Nashville City Hospital,  
Surgeon in Chief to the Womans' Hospital of the State of Tenn.

Duhrssen's statement, that a woman at the climateric is in more danger from cancer of the uterus than is a soldier while engaged in actual warfare (W. W. Grant, Denver Medical Times, August, 1899), is probably no exaggeration.

Welch, in an article written in 1900, presented the statistics of cancer in various countries, and a fearful compilation it is. Of primary cancers, according to this table, 29.5 per cent. occurred in the uterus.

\*Read at the regular meeting of the Nashville Academy of Medicine, Tuesday, March 1, 1904.

There is some difference of opinion amongst investigators, as to whether cancer is upon the increase or not. Dr. Bovis, in an article published in 1902, goes very fully into the subject. He gives full credit for the more careful investigations made by medical men within recent years. He allows for increased knowledge, and better compilation of statistics, and yet believes there is a greater prevalence of cancer now than formerly. He thinks there is much truth in Parks' well-known and often quoted statement: "If the same death rate is maintained for the next ten years, the State of New York will have more deaths from cancer than from tuberculosis, smallpox and typhoid fever combined. Yet a few cases of smallpox in a community invariably occasions more or less of a panic and drives the inhabitants to seek prevention in vaccination; while the existence of cancer, and it is ever present, causes no comment, because it is not speedily fatal, it does not at first produce loathsome conditions, and it is but little, if at all infectious.

In England statistics go to show that the mortality from cancer, in 100,000 of the population, was in 1880, 51 and in 1900 82.9. This increase is almost the same in all the large centers of other foreign countries from which reliable data is obtainable. Here in the United States the disease is not so prevalent, yet the statistics for Washington show in 1880 60, and in 1900 70.3 per 100,000 of population. The increase is greater in Buffalo and Baltimore and in the State of Massachusetts.

These statistics demonstrate fully that the disease is sufficiently in evidence to arouse the medical profession against its onslaught, even though the general public be apathetic about the subject.

That the disease is a local one, and curable at some time in its course, can hardly be doubted. Reamy, of Cincinnati, has reported cases of undoubted cancer of the uterus, treated by hysterectomy, that have remained well after periods of from ten to twenty-five years. Noble concludes 20 to 30 per cent. of his cases operated upon remain well. The results of the work done and reported by Howard Kelly, Boldt, Montgomery, Irish and others demonstrate about the same results in producing absolute cures. It is true, Baldy, of Philadelphia, draws a more gloomy picture, and emphatically states that

the number of cures does not exceed 5 per cent. Such a conclusion may probably be correct, if it be made to include all the patients who suffer with this disease, those that come under observation so far advanced that nothing can be done except to relieve their suffering, as well as those to whom hope of permanent relief may be held out.

The percentage of permanent cures, however, must be influenced largely by the quality of the medical men in the community from which these statistics are taken. Kehr, when asked why it was that he met with so many cases of gall stone disease, replied, that "it was because his friends, the internists, were such expert diagnosticians;" so a surgeon, reporting a large percentage of cures from operations for cancer of the uterus, may with justice say that his success was due to the expertness of his friends, the general practitioners, in making such an early diagnosis, that he was enabled to operate at a time when a cure was possible.

The disease is much more prone to affect women who have borne children, than those who have not been married; or, being married, have remained sterile. Emmet contends that this is due to the injuries to the cervix that result from child-bearing, and he practices and advises the repair of all such injuries before the climateric. Lapthorn Smith, of Montreal, in a recent article, lays stress upon the same preventive treatment. Bassi (quoted in the Jour. Am. Ass., Jan. 17, 1903), reports observations upon 1,000 repaired lacerations of the cervix with subsequent freedom from cancer, and 1,000 cases of injuries to the uterus that were permitted to go unrepaired, in which 21 cases of cancer were subsequently observed. With such a record before him, he necessarily advocates very strongly repair of all injuries to the uterus.

The limit of this paper will not permit me to discuss at length the theories advanced as to the cause of cancer, were I inclined to try your patience with a dissertation upon this still unsettled question. It will suffice to draw your attention to certain facts in its etiology, with which you are familiar from your own observation.

That hereditary tendencies or a vulnerability to cancer may be inherited, can no more be denied than that other predispositions are transmitted. If the tumor matrix (pre natal or post natal) theory be accepted, and it be granted that a

diminution of physiological resistance of the tissues, whatever that may be, is sufficient to admit of rapid proliferation of the tumor matrix cells, then we may safely assume that this impaired resistance may be inherited.

**Age**—Cancer appears usually at a time of life when the waste is greater than the repair; hence, lowered vitality and a lessened resistance in some way stimulates “rests” into active cell proliferation.

**Traumatism**—No amount of injury of itself has ever been proven to be the actual cause of cancer. The irritation of a pipe, a blow upon the breast, or a laceration of the cervix, of themselves, are insufficient to account for the disease; but in an already weakened physiological resistance in the tissues, because of age any one of these may be the spark required to excite into active flame the dormant fires of an old tumor matrix. In the cervix uteri, lacerated by child-bearing or other forces, there is another factor to which I may with profit invite your attention. During the healing process of lacerations, post natal rests may be formed by the involving or including of epithelial cells. These, by the power known as physiological resistance, remain dormant, until the organ takes on senile changes with a diminution of physiological resistance, when they may suddenly become actively proliferating and produce cancer. The early removal of the injured parts of the cervix, as advised by Emmet, for the prevention of cancer, and the satisfactory application of this plan by Bassi, who demonstrated its efficiency in a series of 1,000 with and without operation, is the logical sequence of a belief in this theory of a tumor matrix, held in abeyance by physiological resistance, until this resistance is overcome by age or injury.

This tumor matrix theory bears out the truth of the accepted teaching that cancer is at first a local growth and that its early removal is not followed by a return. It should, however, be borne in mind that a tumor matrix in the uterus does not preclude the possibility of rest or inclusion masses (one or many), existing in other parts of the body, and that impaired physiological resistance may permit them to spring into activity subsequently to the early and complete removal of an actively developing tumor matrix in the uterus or



mamma. This is in no sense of the term a return of the original growth, though it might be an argument in favor of the heredity of malignancy.

The whole theory of cancer formation as well as the facts observed in connection with its growth and cure, prove that its complete removal is possible when it is early attempted. It follows then that an early recognition of the disease is essential, if we are to hope for permanent relief from its dreadful influence.

An early diagnosis is by no means easy; nor is it always possible; yet much more can be done towards its recognition in its first stages, than has been accomplished in the past.

The United States census shows that the average physician signs one death certificate for cancer every three years; and as there are about 150,000 doctors in this country, the deaths from cancer yearly is 43,000. This is a large clinical field, hence the lack of opportunity to study this disease in all its phases cannot be advanced in extenuation of the appalling apathy, to speak mildly, shown by so many of us, towards the marked early symptoms of the disease.

Wiener (Am. Jour. of Obstetrics, vol. 40, page 722), in speaking of the early diagnosis of uterine cancer, says: "Every error in diagnosis costs a human life; every delay endangers one." If this be true, and I believe there are but few men who will have the temerity to challenge his statement, our duty as physicians is so illumined that it should shine out clear and bright under the most befogged conditions. A human life sacrificed! For all the wealth of India what conscientious physician would stand under the burden. A human life endangered! What lover of humanity would permit it? And yet, sufferers from uterine cancer are permitted to go unexamined until the odor from the breaking down tissues takes voice and cries to the highest heavens, a warning against the deadly enemy that is sapping the vitality of God's chiefest handiwork.

How shall we recognize trouble in its incipency? The problem is a difficult one. The symptoms uppermost in the minds of the generality of practitioners at the present time, and indeed relied upon for diagnostic purposes by not a few excellent men, with large practices and wide clinical experiences are growth, hemorrhage and odorous discharges. These

men are no dreamers about the results to be obtained by exaggerations, causal or mental. They are hard, practical, common sense fellows, who use their five good special senses when then can. Touch, sight and smell are to be relied upon and they make the diagnosis by their use, and the diagnosis is almost invariably correct. But of what value is this diagnosis to the patient? In most cases it is of little or none; when the disease has reached the point where it may be detected by the nose or fingers it has advanced to a stage in which the most thorough and complete surgical procedure will probably fail to remove all of the cancerous affected tissue. This kind of diagnosis furnishes to the surgeon the class of cases described by Baldy, as being always sooner or later followed by recurrence and death.

I have said that an early diagnosis is fraught with difficulties; but it is not impossible.

That an early recognition of this fatal malady may be made, it is necessary that the patient be seen when the first symptoms manifest themselves; unfortunately, the general public is not yet educated to the recognition of the nature and character of these early symptoms, or to the importance of seeking relief in the first stages of malignant disease. Here is the first duty of the physician, in our efforts to lessen the prevalence of cancer of the uterus. Medical students and medical practitioners should have it impressed upon them that women should be made to understand:

1. That cancer is prone to occur between the ages of 35 and 55.

2. That it is a local growth at first, and curable in its early stages.

3. Irregular or unusual uterine bleeding at any time in life, but more especially between the ages of 35 and 55, is a symptom requiring investigation.

4. That a return of the flow, after the establishment of the menopause, is one of the gravest symptoms.

5. That leucorrhoea is a symptom of a diseased condition requiring investigation.

6. That change of life means cessation of menstruation, and that increased flow at a time when menstruation is expected to stop, is a danger signal.

7. That pain is a symptom that appears late and should not be expected or looked for as a sign of cancer in the early stages.

When the general public understands the importance of these teachings, women will not be found going about in fancied security, while they are tottering on the brink of the grave as the result of advanced uterine cancer. No longer will we hear the often repeated phrase, "Oh, there is nothing the matter with me, except change of life," from women whose emaciated frames and cachectic counterances speak loudly of the silent ravages of deadly diseases. The medical profession will have done its first duty, and cancerous patients will seek professional advice, at a time when the disease is in its early stages, and the physician will have the opportunity of performing his second duty.

An early diagnosis of uterine cancer is the second duty of the physician to those affected by this disease. The first symptoms of uterine cancer are as a rule sufficiently marked to excite suspicion and occasion investigation. The picture presented by the disease, when carefully scrutinized, is quite as clear as that created by many other affections of the human body.

Haemorrhage is perhaps the most common symptom of the trouble. It may be almost pathognomic or it may be but a faint suspicion that will attract the attention of none but the most careful observer. The appearance of a bloody vaginal flow from a woman past the climateric and whose menstruation has not appeared for a year or more, is in the majority of cases indicative of malignant disease.

During the menstrual life of a woman, and more especially in its late years, irregularity of the flow, increase in quantity, staining, or shows following intercourse, exertion or excitement, are suspicious signs that should lead to investigation. The history of the patient's menstrual life will frequently aid in determining the cause of the flow which may be due to many other conditions besides cancer.

Leucorrhoea is a symptom of cancer which in my opinion is not given due weight. The free uterine or cervical secretion, brought about by a too free blood supply to the uterine glands, is a symptom of many diseased conditions; but it is not

a symptom that should be lightly passed by without at least an effort being made to learn the disease occasioning it.

During the active proliferation of the cells of a tumor matrix, whether of pre natal or post natal origin, local congestion results, and as a consequence, over secretion by the glands of the part, a leucorrhoea.

Cervicitis or endometritis will occasion a leucorrhoea which may persist for a long time; but if, as the sufferer reaches the usual period when menstruation may be expected to cease, the leucorrhoea increases, malignancy should be suspected and the suspicion will be intensified if the character of the flow changes from a more or less thick discharge to a watery one. If it becomes stinking, the disease will have gone beyond the early stage.

Palpation is oftentimes of great value in determining the nature of a lesion about the cervix. The trained finger will sometimes detect a perceptible difference between the hard, enlarged tissue of ordinary inflammation and that of a neoplasm. In the early stages of the disease the microscope and the skilled microscopist are nearly always necessary to fully determine the condition. It should be borne in mind, however, that both are fallible, and that a failure, on one or many occasions, to secure a correct diagnosis by these indispensable assistants, is no argument against their employment. We ourselves are probably in many cases responsible for the failure of the pathologist in his attempts to aid us in our work. The tissue we present may be secured with indifferent care. If taken from the cervix, the actual growth may not have been included in the dissection. If from the uterus, the curette may have failed to reach the diseased tissue. The dull curette is valueless as an instrument with which to remove tissue from the uterus for microscopical examination when cancer is suspected. The sharp curette should always be employed.

One other way in which we fail towards the pathologist, is in not calling him to our aid more frequently, and especially in cases from which he may get a reasonable fee. Clinical deductions and microscopical findings are both essential to diagnosis in most cases of cancer in its earliest development.

Later, when the disease has produced a heaping up of tissue or a crater-like ulcer, with severe and frequent bleedings and perhaps a foul smelling discharge, the disease has its

name written over it in glaring letters that may be spelled out by him who knows only the alphabet of the medical language. But then, it is no longer a local affection with a fair chance of removal. The vagina, or bladder, or rectum, or pelvic lymphatics, perchance will be involved, and though a seemingly successful removal may be accomplished, yet after a variable time, extending from one month to a few years, the disease in 95 to 100 per cent. of the cases will recur and bring about a fatal ending.

Our second duty having been performed and an early diagnosis having been made, we still have another duty before us of equal importance with the first two.

Our third duty is to subject the patient to an immediate and complete removal of the tissues involved by this growth. There should be no uncertain sound in the physician's warning voice. The facts should be boldly and emphatically set forth. Even though the information imparted seems almost brutal in its bluntness, valuable time must not be wasted, a valuable life must not be carelessly sacrificed; but if a life is to be lost, let it be by a moral suicide, never by a moral murder.

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### SHOULD EMBRYOTOMY BE DONE ON THE LIVING FOETUS? \*

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BY GEO. C. TRAWICK, M.D., OF NASHVILLE, TENN.

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Ayres states that the maternal mortality in cases of embryotomy done early and with skill should be only one or two per cent. But according to published records in the hands of all practitioners, its total mortality reaches about 15 per cent. Improved technique and better knowledge of the surgery of the abdominal cavity have wrought great changes in the mortality of Caesarean section. In the hands of skillful operators the maternal mortality of the Sanger operation is about 8 per cent., and that of the Porro operation is 38. About one-fourth of all babies delivered by section die. These statistics are liable to be misleading, from the fact that every practitioner performs at times craniotomy, while perhaps only the more skilled surgeons perform Caesarean section. If as many men

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\*Read at meeting of the Nashville Academy of Medicine.

should do section as perform craniotomy the statistics of Caesarean section would not be as brilliant as they now are.

Opposed to embryotomy are the operations of symphysiotomy, induced labor, and Caesarean section. Any one of these proceedings may be instituted with a fair chance of saving both the mother and the child, while embryotomy is always done in the interest of the mother, the child being sacrificed.

It may be taken as an axiom that no woman should be allowed to die undelivered during labor. If she die suddenly, the child should be delivered at once through an abdominal incision. If the sacrifice of one is essential to the life of the other, dispose of the child and save the mother. The Roman Catholics formerly taught that even though it might be impossible to deliver the child without first killing him, to do so would be mortal sin. And it also held until lately that the infant could not be baptized in the uterus, as it must be natus before it could be renatus by baptism. The present teaching, however, is that the child can be baptized in the uterus. Religious belief of the patient should bear no weight in reaching a conclusion as to the plan of procedure.

Symphisiotomy is not favored by modern operators. The operation usually necessitates the subsequent application of the forceps, which places the life of the foetus in greater jeopardy, while the after-treatment of the mother is complicated and tedious, and she is liable to have a resulting lameness. (Leopold, *Jour. of Obs. & Gyn.*, November, 1899.)

Such little hope has been held out to the women by many operators, who advised section to save the off-spring, that both husband and wife in many instances have entertained feelings akin to despair for the safety of the mother. Napoleon when appealed to by Du Bois said, "Treat the Empress as you would a shop-keeper's wife in the Rue St. Martin, but if one life must be saved by all means save the mother." Henry VIII., when thus questioned before the birth of his son Edward, exclaimed, "Save the child by all means, for other wives can easily be found." Of late years the happy results following Caesarean section have done much to efface the dreadful feeling of despair which formerly oppressed the parents when this procedure was advised. Barnes states that "It is no longer permitted to us without ample proof of clear necessity to sacrifice the child in order to save the mother. The cases

in which the two are supposed to stand in antagonism are vanishing before the light of modern science and skill." The time is coming when we are bound to save the lives of both. An infant come to maturity is destined for something greater than to have its life extinguished by means of a perforator. Lusk holds that Caesarean section is preferable to embryotomy even with a conjugate diameter of 2 1-2 to 3 inches, when the child is alive. Embryotomy in a pelvis contracted to this degree is as dangerous to the mother as section. Absolute indications for a section are a pelvic canal so contracted that delivery by natural passages is impossible, or when the pelvis is obstructed by a solid tumor. The relative indications have a much wider scope, and it is in the border cases that the best judgment of the obstetrician is brought into play. If the true conjugate measures 2 1-2 inches or under, the woman should be advised to go to full term and be delivered by section, this offering the greatest hope for the safety of both. If the conjugate measures 3 inches, a living child may be delivered with a fair chance to survive by inducing labor at the twenty-eighth week or later, according to the relative size of the child's head and the mother's pelvis. Many children are born spontaneously at full term through a pelvis of 3 1-4 inches conjugate, and nature should be given a chance to expel the foetus with this degree of contraction.

If the woman is seen early in pregnancy, labor should be induced at an appointed time after the child reaches viability, when the pelvis is so contracted that the chances are against the passage of a full term child through the natural way. It is sometimes very difficult to determine just when labor should be induced. The proper time is when it is found that the foetal head has reached the greatest growth that the pelvis can accommodate. This cannot be absolutely determined, but a close approximation can be made. The mother should be completely anesthetized once a week after the foetus has reached viability, and the foetal head forced down into the pelvis. When it is found that the adaptation of the head and pelvis is complete, labor should be induced at once by inserting a bougie or water bag into the uterus while the patient is yet under anesthesia. But if this woman with the moderately contracted pelvis does not call in her attendant until after the onset of labor, he should decide at once, before his patient



becomes exhausted by prolonged labor, whether the chances are against the delivery of a live child by the natural forces. If the woman gives a previous history of difficult labors with a succession of still-births, he may wait until full dilatation of the cervix before making any attempt at delivery. While waiting, every preparation should be made to perform section, if necessary. If the head enters the pelvis by a full dilatation, then the chances are in favor of a natural delivery. If it does not enter, section should be performed at once. Podalic version should ever be considered in a doubtful case where section may become necessary. A woman may give birth to one living child, and yet section may have to be done at some subsequent pregnancy, on account of increase in size of the foetus. The last child of a multiparous woman is usually much larger than her first. Craniotomy is never justifiable when the mother has been under observation since early pregnancy. It is the duty of the practitioner to instruct his lying-in patients to have a pelvic examination with instruments made by the time the child reaches viability. Embryotomy of the living foetus will be a lost art when all our lying-in cases are in our care from the beginning of pregnancy.

What is to be done in private practice when the case demands either section or embryotomy, but the skill and experience of the operator are not great, the surroundings are unfavorable, and trained assistants cannot be obtained? The beautiful results of Caesarean section have been attained in our best equipped hospitals, with every assistance at hand. Leopold holds that in private practice if the surroundings do not afford the essential requirements for the abdominal operation, and if the patient cannot be transferred to a hospital, that Caesarean section is contraindicated, and advises perforation of the foetus. Until it has been established that the maternal mortality after section is no greater than after craniotomy, it would be foolish to say that mutilation of the living foetus is never justifiable. Our fathers in medicine were taught to perforate a child's head if it could not be easily extracted with the forceps. The great reversal in sentiment, both with the public and the profession, is in favor of conserving the life of the child.

There are other forms of dystocia than that caused by contracted pelvis, which may necessitate craniotomy. I would



not hesitate to perforate an after-coming head, after version for central placenta praevia—if the cervix was incompletely dilated and retracted about the child's neck. The maternal mortality is very high in central placenta praevia, and nothing that adds to her danger should be done. The lower uterine segment in this anomaly is very easily torn on account of being so thin and friable. The foetal mortality is about 75 per cent. in most favorable cases, so considering the great danger to the mother, and the small chance for the child, the after-coming head may be promptly perforated and thus reduced in size, when this maneuver will save the mother a bad laceration of the cervix or body of the uterus. In cases of impacted transverse presentation, when it is impossible to reduce the impaction, the question of performing section then becomes a very serious one. The contraction ring of the uterus is always well marked in these cases and the lower zone very thin, making it dangerous to the mother to perform any manipulation in this segment. At the same time, the chance of delivering a live baby by section is very remote, on account of the violent compression it has been subjected to, and because of the difficulty in removing the child after the uterus has been opened. As a rule, decapitation can be done without subjecting the lower uterine zone to very much additional tension and should be done in preference to section. But if in the opinion of the attendant the uterus cannot be subjected to any manipulation without danger of rupturing, section should be done, no matter whether the child is alive or dead. Let us hope that the only cases of transverse impaction which we shall meet with are those referred to us by some ignorant midwife or granny-woman, or where the mother has neglected to call for assistance. No intelligent physician will allow a shoulder to become jammed in the pelvis, if he has had full charge of the case.

It is justifiable to perforate the head of a living child when it is over-distended from some intra-cranial disease, such as hydrocephalus. In a case of this nature the condition must be positively diagnosed. Aseptic puncture of a fontanelle is not necessarily fatal to the child. Destruction of foetal life in other monstrosities cannot be objectionable, for they usually die anyhow a few hours after delivery, and the mother should not be exposed to the risk of section, merely for the sake of a

monster. A face presentation, chin posterior and low in the pelvis is as impossible for natural delivery while in this position as an impacted transverse presentation. Caesarean section has been done for this condition, but the results have been bad. It is very difficult to remove the child after opening the uterus, in time to prevent its being asphyxiated. Craniotomy seems to offer the best results in this condition, if the attempts at forceps delivery and rotation are unsuccessful.

To review: In cities where modern conveniences can be obtained, mutilation of a living baby should never be considered when the woman has been under the care of her attendant throughout pregnancy. It is the duty of the physician to instruct their patients, who expect to be confined, the absolute necessity of an examination by the seventh month. When women have been educated to this end, and when skilful assistance can be obtained, craniotomy will never be considered on account of a contracted pelvis, and with a living foetus. With a pelvis contracted to  $2\frac{1}{2}$  inches or under, section should invariably be performed. With a less degree of contraction, induced labor offers very great hope of saving mother and off-spring, without the necessity of section. Labor should be induced when the growth of the baby's head has attained the greatest size that the pelvis can accommodate.

Until it is demonstrated that section in general practice, particularly in the country, without the necessary conveniences, has no greater mortality than craniotomy, we cannot say it is never justifiable to mutilate a living baby. And when women refuse to call assistance until well advanced in labor, they will occasionally have to suffer by having their baby's head perforated because of their negligence. When the foetal pulse is irregular, movements weak or absent, and doubt is entertained as to the survival of the baby, Leopold holds that the mother should not be subjected to Caesarean section, but that embryotomy should be performed. Such anomalies as central placenta praevia or hydrocephalus sometimes call for embryotomy of the living child. An impacted shoulder, or face presentation with chin posterior offers too scant a hope for a living baby by section, and craniotomy frequently becomes necessary. No intelligent physician will allow these conditions to be present.

It becomes necessary then, for our pregnant women to place themselves under observation from the outset of pregnancy, to call for her attendant as soon as labor begins, and that a skilled operator be in reach before we can say that embryotomy should never be performed on the living foetus.

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## STAMMERING AND STUTTERING.

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BY DR. JAMES M. BROWN, OF CHICAGO.,  
Assistant Professor Laryngology, Chicago Polyclinic, Chicago.

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In connection with the term stammering it is customary to associate all forms of speech impediments, which, for the most part, have with few exceptions been almost wholly ignored by the medical profession. Stammering and stuttering are terms used synonymous with each other; Kussmaul, however, makes a distinction between the two terms, stating that in stammering the individual sounds are difficult of production, while in stuttering they are syllabic combinations. Stammering is often accompanied by some defect in the organs of articulation and which is not present in stuttering.

Stuttering is the most common form of speech disturbance. The articulation is distinct and the separate sounds are usually produced, but there is a difficulty in connecting the consonant with the succeeding vowel, which is hard to overcome. This condition is seen more frequently in children, between the ages of 4 and 14 years, and may arise from imitation and inheritance. It is also aggravated or produced by disturbances of nutrition, an interesting example of which is reported by Holt. A boy, 4 years of age, very anemic, slept poorly, and suffered from malnutrition as a result of confinement indoors. He began to stammer and in a short time the affection became well marked. A few weeks in a different climate under suitable treatment improved the general condition, weight increased, and in time the defective articulation disappeared entirely.

Such disturbances are often analogous to chorea, or an acute illness, and when occurring from these conditions are mostly of short duration, and it is important that all such cases receive proper medical attention early, the prognosis being favorable.

Stammering is an impediment which can apparently be

traced to imitation, from which it had either taken rise, or of which it had become formidable, from a state, perhaps, of mere indistinctness or careless stuttering, which had predisposed the affection. Spasmodic stammering generally combines with its own peculiar contortive efforts the incontinent hurry of stuttering, the gasping breath catches, and silent straining of hesitation.

Nervousness, in many instances, aggravates impediments of speech and it is the popular opinion that nervousness is the cause of stammering, but it would be more correct to say, in many instances that stammering is the cause of nervousness. Constitutionally nervous persons are undoubtedly more liable than others to be affected with disordered speech, but there is undoubtedly a greater number of so-called "nervous" persons than stammerers, and were stammering the result of nervousness, the larger proportion would certainly be found among those affected by impediments.

Numerous treatises and advertisements for the cure of speech disorders have, from time to time, been brought before the public, their authors, for the most part being practitioners of the curative art rather than expositions of the *modus operandi* of cure. Mystical theories as to the cause and means of cure have been advanced and portrayed the malady in the darkest and most profitable mystery. All impediments of speech should, however, be under the care of the physician, the subject being dealt with by many medical authorities, but more comprehensively by Kussmaul and Wyllie, they advancing the cause of the common variety of speech disorders due to the delayed action of the laryngeal or vocal mechanism in attacking the first syllables or words. The incoordination of movement being due to an underlying cause, as abnormalities in the upper air passages, nervousness, inheritance, or being acquired by imitation.

The stammerer, as a rule, experiences difficulty usually during the production of the first syllable or an ordinary word. These two mechanisms, laryngeal and vocal, are, as it were, out of gear, and can be put in only by an effort; when this effort succeeds in educating the first syllable, the others follow, as a rule, without difficulty. It is only after the completion of the word that the two mechanisms fly again out of gear.

34 Washington Street.

## *Abstracts.*

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### SUBLAMINE IN THE TREATMENT OF PARASITIC SCALP DISEASES. \*

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BY WILLIAM S. GOTTHEIL, M.D.,

Dermatologist to the City Hospital, Lebanon and Beth Israel Hospitals,  
New York City

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When sublamine was introduced as a non-irritant disinfectant equal to mercuric chloride in bactericide energy, and possessing far greater powers of tissue penetration, it at once occurred to Dr. Gottheil that the drug had a most important sphere of usefulness, not only as an external antiseptic, but also as a remedy in various parasitic dermatoses and as an antiluetic. For the toxicity, causticity and irritancy of corrosive chloride limit its use in the former and make its injection in syphilis our last resort instead of the regular treatment.

Sublamine was found by Kroenig, Blumberg, Schenck, Zaufal, Paul, Sarwey and others to possess the same bactericide power as the bichloride, but to be so non-irritant that even 2 per cent. solutions can be employed if required, and to have a far greater penetration than the older drug, as it does not coagulate albumen.

During the winter of 1901-02 a ringworm epidemic broke out in a large orphan asylum to which Dr. Gottheil and Dr. George H. Fox were dermatological consultants. The matter was brought to their attention only when the epidemic had assumed alarming proportions. Some 450 out of the 900 children were affected. Many of course had only a light form, but there was a large proportion of deep infection and kerion.

The serious nature of such a state of affairs is well known. Ringworm of the scalp is not, ordinarily, a grave affection; but even under the most favorable circumstances and with the most careful treatment it lasts for months. In public practice the majority of cases are not cured at all. They go from clinic to clinic, getting now a little better and now a little worse, until puberty is reached and the malady cures itself. Meanwhile these children are excluded from school

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\*Abstracted from the Medical News, October 17, 1903.

and grow up in the streets. A similar epidemic in the institution some years before had nearly led to its permanent closure.

The diagnosis was confirmed by microscopic examinations and cultures, and a laboratory was organized for both methods and the control of results. Proper isolation was enforced, and observation wards were instituted in which apparently cured patients were kept for three weeks after treatment was ceased. No case was discharged until cure had been repeatedly proved. All other necessary sanitary and therapeutic arrangements were made; 150 of the infected girls were transferred to Dr. Gottheil's skin service at Lebanon Hospital.

The patients were divided into squads. Every head was closely shaved once a week as soon as the inflammation had subsided sufficiently to permit it. Twice daily each head was thoroughly scrubbed with brush, green soap and hot water.

The remedies employed were chrysarobin, formalin, croton oil, bichloride of mercury, carbolic acid, iodine, and ethylenediamine-citrate of mercury and sublimine in various strengths.

A most determined effort was made to have proper records kept; for here was a chance to determine by comparative tests which plan of treatment gave the best results. Dr. Gottheil was not successful in this, however. Lack of discipline and the fact that often the names of the children were unknown or imperfectly known, or interchanged, helped to create confusion. The patients were scattered in four buildings and at least a dozen wards. Lack of room necessitated incessant transfers of well and sick children. Changes in staff and servants further complicated matters. Hence the records were in a very unsatisfactory state when the epidemic was ended.

Chrysarobin was soon abandoned. It was impossible to keep the children from getting it into face and eyes, and there was a good deal of trouble with dermatitis and conjunctivitis. The diffuse brown stains on the skin doubled the time required for examination. The same objection was made to iodine. This, in combination with goose grease, has lately been highly recommended by Dr. Jackson, of New York, and is undoubtedly an effective preparation. The menstruum is comparatively expensive, however, for use on a large scale, and it caused coloration. At Dr. Fox's suggestion a number of cases were put upon it, but treatment was soon changed.

No definite results were obtained from salicylic acid in any form and concentration. The same is true of pure carbolic

acid, followed by alcohol when too irritating. Pure formalin was used in some cases by a house physician without Dr. Gottheil's consent. It cured the patches to which it was applied, of course, but at the expense of sloughing and destruction of scalp tissue. In 10 per cent. solution, which was well borne, it did not seem to make much change in the patches.

Bichloride, sublimine and croton oil were found sufficient for all cases. The first was employed in 1 1-000 solution, but many could not stand its vigorous use twice daily, and often only 1 2-000 could be used. Its effect was very slow, probably because of deficient penetration, but we persisted in its use for purposes of comparison. In most cases final recourse was taken to 33 per cent. of croton oil. This was applied several times in succession until a vigorous reaction took place. Then an ordinary soothing application (usually 3 per cent. salicylated oil) was used until the inflammation subsided, when the bichloride was again employed.

Of the two ethylenediamine-mercury compounds, sublimine was more largely used. At the time the epidemic began the citrate was the only preparation obtainable; but since the properties of the two are similar they can be considered together. They are much less irritant than bichloride. All stood 1:1,000 sublimine very well; indeed, in obstinate cases 1:750 was used without trouble. Stronger solutions than that, however, gave trouble. It is possible, of course, that the shaving and scrubbing rendered the scalps hypersensitive. But sublimine is much less obnoxious to tender or inflamed skins than bichloride and can be used in about twice the strength permissible of the latter.

Over 100 cases were treated with sublimine. As with the other drugs, they were not selected, but included cases in all stages of the affection; some had merely a single patch, whilst others were in an advanced and generalized stage of the disease. In the latter class were a number of older children who had had ringworm of the scalp for years and whom we suspected with good reason to be uncured cases from an epidemic of several years ago. They had been for months and years at Randall's Island, the city institution for orphans, and had been sent back to the asylum as cured. That this was not the case, however, is shown by the fact that some of them formed



part of the contingent of chronic scalp cases that were always present in the asylum and which undoubtedly formed the nucleus of the present epidemic. Some of the cases were not cured when the epidemic ended. Dr. Gottheil believes that they belong to the small number of really incurable cases and that their retention in the institution will lead to further trouble.

All others did very well indeed under sublimine. Its action was more rapid than that of bichloride, as might be expected from the fact that with equal bactericide power it has greater penetration, and can be employed in much stronger solution. There can be no doubt that it was the most effective treatment employed.

Dr. Eckstein assisted in the microscopic and bacteriologic test for the presence of ringworm at the beginning of the epidemic. The astonishing fact was noted that a parasite indistinguishable from that of ringworm could be cultivated from scalps that were apparently perfectly healthy. The trichophyton was seemingly present on most or all the scalps, possibly in an attenuated or non-virulent form. Perhaps it was the usual form kept in depressed growth by prophylactic measures. The bacteriologic test of cure was therefore abandoned and only microscopic evidences relied upon. Cases in which repeated cultures had been made with negative results, and which were therefore discharged as cured, gave positive cultures later, though their scalps were apparently healthy.

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### INTRAVENOUS COLLARGOLUM INJECTIONS IN SEPTIC AFFECTIONS. \*

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BY GEORGE TUCKER HARRISON, M.A., M.D., OF NEW YORK.

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A young married woman who had an abortion procured without antiseptic precautions, came under the care of Dr. Gessner Harrison with a severe form of pyaemia. She had a weak pulse, a remittent fever, the right knee joint was very much swollen with extensive effusion, and there was an abscess of the gluteal region. As the patient was growing

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\*Read before the Medical Society of Virginia, 34th Annual Session, Roanoke, Va., Sept. 15-17, 1903; abstracted from The Virginia Medical Semi-Monthly, January 22, 1904.



progressively worse under ordinary treatment, I suggested to Dr. Gessner Harrison, whom I met in consultation, the intravenous injection of collargolum, which was performed. The next day improvement was manifest, not only by temperature and pulse, but also by the greatly altered general condition; the patient expressed gratification at the cheerfulness and hopefulness of which she was now conscious. Two more collargolum injections were given in the following two or three weeks. The fever continued, as a large abscess developed in the thigh. In August I incised this abscess in the middle of the thigh and evacuated an immense quantity of pus. The incision was made on the outer side of the thigh, a counter opening being made on the inner side. Through and through drainage with aseptic gauze was effected; and the cavity was filled and irrigated with hydrogen peroxide. When the gauze was taken out of the cavity the following day, I was surprised to find that not a drop of pus came out, but only a serous or lymph-like liquid; and from that time on a similar condition existed. So rapid a recovery after the evacuation of an abscess of this size I never before witnessed, the effusion in the knee joint having nearly disappeared, though there was yet some stiffness, and the condition of the patient being excellent. The knee joint affection was evidently septic arthritis.

The difference in the course of the gluteal abscess from that of the abscess in the thigh shows the effect of the collargolum. Again and again the patient remarked that it was wonderful how rapidly the abscess had healed; it seemed like magic. To appreciate the splendid results achieved by collargolum it is necessary to bear in mind the clinical picture at the time of the exhibition of the remedy—the rapid pulse, the elevated temperature, the extreme emaciation, the dreadful paroxysmal pains in the lumbar and sacral region, the sensitive septic right knee joint and the swollen right thigh.

The author then details a puerperal case treated in consultation with Dr. George T. Myers at the New York Infant Asylum. The history so clearly evidences the brilliant action of collargolum, that Dr. Myers remarks: "In my experience at the New York Hospital with puerperal sepsis treated by curettage and the various intra-uterine douches, I have never seen such brilliant results as followed in this case after the administration of collargolum."

## THE TREATMENT OF PUERPERAL SEPSIS. \*

BY DR. HIRAM N. VINEBERG, NEW YORK.

In a patient whom I had under observation a couple of years ago, and who was ill for a long time, I made the diagnosis of septic thrombosis of the pelvic veins on the right side. The patient was very seriously ill, had repeated severe rigors, followed by high temperature. The uterus behaved normally and involution progressed as it should. There was no pelvic exudate, but I could feel a round, hard cord along the infundibulo-pelvic ligament; the adnexa were apparently normal; there were no signs of peritonitis. At one time during the illness a prominent internist who saw the patient in consultation concurred in my diagnosis of pelvic phlebitis and thought he found evidences of septic endocarditis. The patient was in a precarious condition for weeks but finally made a good recovery, the treatment consisting of the usual stimulating and nourishing agents employed to combat sepsis, together with free inunctions unguentum Crede. There were no external metastatic abscesses. There was no bacteriologic examination made of the uterine discharge for the reason that when the sepsis became manifest, which was rather late in the puerperium, there was practically no discharge from the uterus. I had reason to suspect a gonorrheal infection, as the husband had suffered from an acute attack of gonorrheal urethritis a short time before the wife conceived, and during the early stages of the pregnancy there was a marked erosion of the cervix with a copious mucopurulent discharge.

It may be appropriate here to say a few words in reference to the use of collargolum or unguentum crede. I am in the habit of using unguentum crede in cases of sepsis where I can find no lesion which demands surgical intervention, or in those cases in which the gross source of infection has been removed by surgical means and the manifestations of sepsis still persist. I have gained the impression from its use that it is of some service either in aiding the system to eliminate the toxins produced or in some way counteracting their deleterious effects. Certain it is that several desperate cases in which the

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\*Abstracted from the Journal of Obstetrics, September, 1903.

silver was employed by inunction ended in recovery, and it did seem to me that the favorable result was in a measure induced by the inunctions of the silver.

Before closing I desire to lay especial emphasis on the importance of watching very carefully every puerperal woman who shows the slightest elevation of temperature. If it be assumed that such elevation denotes sepsis unless some other cause unmistakably accounts for it, and the proper treatment instituted at once, then, in my opinion, it will rarely occur in private practice that a case of puerperal sepsis will be encountered in which any serious surgical intervention will be needed.

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## *Clinical Reports.*

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### CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

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STATED MEETING HELD FEBRUARY 1ST, 1904.

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The President, Dr. James Hawley Burtenshaw, in the Chair.

#### GASTROPTOSIS.

Dr. W. V. V. Hayes showed a patient, a woman 38 years of age, who first came under his observation three years ago, suffering from gastroptosis. She gave a history of severe gastric pain, which ran through to the back, coming on after eating and lasting for two or three hours. She vomited frequently, and was unable to obtain relief until the stomach was empty. Eructations of gas, anorexia and constipation were marked symptoms. The stomach, on examination, proved to be sensitive to the touch, and was displaced downward about the width of three fingers, as shown by the position of the lesser curvature. The functional signs revealed an adenasthenia gastrica, there being no free HCL and a total acidity of only 20. Tincture of nux vomica and fluid extract of condurango were administered. (Incidentally, in the course of treatment, she was relieved of a tape worm). The Vanvalzah-Nisbet bandage was applied to the abdomen. This

bandage reverses the action of the ordinary corset and pushes the stomach upward and backward. Occasionally the use of a supporting bandage produces a decided change in the position of the stomach, but ordinarily this can hardly be expected. There was a distinct improvement in the condition of the patient. She had gained several pounds in weight, which doubtless helped to keep the stomach in better position. Her general condition was much improved, and there had been practically no symptoms for three months. The supporting belt was no longer required.

She was given solutions of bicarbonate of soda and tartaric acid, about a minute apart, to demonstrate the improvement in the position of the organ, which was found to be two fingers' breadth higher than when originally observed.

#### ATROPHIC GASTRITIS.

This patient, a man fifty years of age, was also presented by Dr. Hayes, who first saw him in 1897. The patient then gave a history of having suffered for about a year from vertigo, nausea, regurgitation of food and expulsion of gas three hours after eating; his appetite was poor, and there was a tendency to diarrhoea and extreme nervousness. He had been moderately addicted to the use of alcoholic drinks, and had taken large amounts of strong medicines. He was treated for syphilis in 1890-1891. Analysis of the stomach contents during the past six years gave practically the same results. The total acidity ranged from 6 to 10. No free hydrochloric acid was found. Ferments were absent, but mucus was always present. The condition was one of atrophy of the mucus membrane. The speaker said that there had been very little change in the condition of the patient and there would probably be very little, so long as the motor function of the stomach was retained and the intestinal compensation maintained, but if these should fail, very little could be done to help him. During the six years the stomach had practically done nothing except to pass the food onward. This patient demonstrated how a person with atrophic gastritis may live for a long time in comparatively good health.

Dr. Morris Manges opened the discussion of the second patient presented by Dr. Hayes. He called attention to the statement which had been made in the presence of the patient,

that large quantities of the iodides which the man had taken were probably responsible for the atrophic gastritis. The speaker said that in his opinion atrophic gastritis was one of the most complex and least understood of all diseases of the stomach. There is no positive evidence as to whether it comes from the mucosa or the submucosa further down. It is known that cases of pernicious anemia exist and are associated with atrophic gastritis. The exact pathological classification is unknown. As regards the influence of strong medicines in the causation of gastritis, it may occur as well in the late stages of alcoholism, but that is an entirely different picture. Atrophic gastritis is largely due to changes in the portal circulation, secondary to changes in the liver itself, and there is a clear distinction in the etiological elements of the cases, and subsequent changes have nothing whatever to do with the disease. Many syphilitics have had larger doses of iodides than the patient under discussion, and no atrophy resulted, but the patients derived the greatest benefit from this medication. The speaker said he prescribed for all cases of atrophic gastritis 5 to 7 minims of hydrochloric acid at each meal, for the remainder of their lives, and thought that this treatment and the motility of the stomach were the chief factors in the disease.

#### DERMOID CYST.

Dr. James P. Tuttle showed a very unusual specimen of a dermoid cyst. There was practically no history until the day previous to the operation, when the patient, a girl about 18 years of age, went to the office of her family physician and complained of difficulty in making her bowels move, and excessive pain when they did move. She was given an enema and a laxative. The next morning she had a chill. Examination then revealed a tumor in the left inguinal region about the size of a small orange. Her temperature was about 100 degrees F. Three hours later the tumor had apparently increased about two-thirds in size, and the girl's temperature was 102 degrees F. Dr. Tuttle was called in consultation and found her with a temperature of 102 degrees F., inability to move her bowels, and a fluctuating mass in the left iliac region and in the recto-sigmoidal juncture. His diagnosis was hematoma. The following day her pulse was faster and there seemed to be

hemorrhage, so the vagina was opened through the posterior cul-de-sac, and about six ounces of clear, serous fluid was evacuated. Passing his hand further up, a large tumor was found, and the operator, supposing it to be an abscess, poked his finger through a rent in the apparent capsule, and fluid gushed forth, which, on bacteriological examination, proved to be filled with fat. Inside the capsule was a tumor, which was removed through the vaginal opening. On one side of the tumor were four protuberances, just in line. This mass, which was on the left side, was attached by a pedicle to the posterior surface of the right lobe of the liver. The tumor had apparently been lying in the posterior cul-de-sac, and the hemorrhage pushed the tumor up to the position in which it was found at the time of operation.

Dr. J. Riddle Goffe said that Dr. Tuttle's specimen was a remarkable one. These masses are commonly found in connection with the ovaries, and the most he thought of the development of a dermoid teratoma, the more inclined he was to believe that it was necessary for some form of degenerate conception to have occurred previous to their development. However, in the specimen under discussion, this was probably not true, as the patient was a young girl, and Dr. Tuttle said that both ovaries were present and absolutely undisturbed. It seemed that one might trace a faint outline of a fetal mass, the larger projection at the top of the mass representing the head, two projections lower down for the shoulders and arms, and two at the other end for the lower extremities.

#### VESICAL CALCULI.

Dr. E. L. Keyes, Jr., presented a large number of specimens of vesical calculi, and gave a most interesting talk on the formation of these stones, the differences in their composition and appearance and the procedures by which they had been taken from various patients. He said that the first interesting feature about stone in the bladder is the different varieties that occur and the manner in which they may be distinguished from each other. If the bladder is opened and the specimen taken out whole, the stone presents one picture, and it is crushed and sucked out through the urethra, the picture differs. The first specimens shown represented stones under the two forms.

The first distinguishing characteristic of these calculi is that they are either primary or secondary. The primary stone forms itself for no reason that can be recognized; the secondary stone is formed by the inflammation produced by the primary stone. While there are a great many different varieties under either head, the chief groups are the oxalate of lime stone, the uric acid stone, and the urate of soda stone. There are many kinds of secondary stones, but they are all modifications of one mixed mass of the various phosphates, and are known as mixed phosphates stones. Among one hundred and fifty stones, all of which had not been examined chemically, the speaker said that as far as he knew, all were included in one of these four classes.

Specimens were shown representing four different varieties of stone under two different guises. Some were composed of oxalate of lime, and were very irregular in shape. For this reason they are sometimes known as mulberry stones. The color is not very clearly brought out, but they vary in shade. A urate stone shown at the same time was distinctly lighter in color than the mulberry stone, and the surface of the former was much more regular, but not entirely smooth. The phosphatic stone is smoother and somewhat resembles white agate in appearance. In the crushed specimens the color is much the same as in the whole stones, but is more distinct. The primary stones are all distinctly darker than the secondary phosphatic stones. Very frequently uric acid and urate stones are mixed in one deposit. Both have a distinctly reddish hue, as compared with the brown of the oxalate.

A point worth noting is that the secondary stone sometimes forms as the result of inflammation caused by the primary stone; consequently in many secondary stones the beginning is primary, and the primary stone rolls about in the bladder, cystitis results, and changes occur in the alkaline urine, which throws out phosphates which are deposited on the primary stone. The speaker showed one stone which had existed for many years as a primary stone before it developed a phosphatic covering. The proper bacteria were not present to render the urine alkaline; a cystitis must have been present for many years before it became alkaline. Another specimen was an oxalate stone through which peaks of oxalate showed through the deposit of phosphatic covering. One great Eng-



lish authority, Dr. Morris, places the percentage of uric acid kidney stones as high as 95 per cent.; in other words, of the many phosphatic stones removed from patients, the greater number are formed over nuclei of uric acid stones.

The speaker next showed the largest stone in his collection, which was taken from a man 36 years of age. The stone had existed for thirty-five years when the patient went to Bellevue Hospital in 1860. A diagnosis of cancer of the bladder was made, and he died without an exploratory operation, exploratory laparotomies not being as common then as now. At the autopsy a stone thirteen ounces in weight was discovered, which was unquestionably the cause of death. The interior of the stone is oxalate, covered by layers of phosphatic deposit. In the oxalate stone the outside and inside are "bumpy," so to speak, and there is no regular formation, while in a uric acid stone in the collection there are systematic thin layers, one upon the other.

The shape of a calculus is sometimes interesting, but not important, perhaps. The stone generally takes the shape of the cavity in which it lies, in a general way. All the stones are concentrically formed. There is a nucleus of what may be termed a "foreign body"—either an actual foreign body or formed from the salts of uric acid. Layers of the same substance or of a new substance keep forming, and in a general way there is a roundish shape, with the exception of the oxalate stone, in which, in certain cases, the nucleus is not central. The speaker showed several stones which had formed upon nuclei of actual foreign bodies. One or two had formed upon the ends of catheters which had broken off in the bladder, and one especially interesting specimen which had formed on the end of a hair. The patient developed a tumor with a hairy surface, and the inflammation thus set up caused a cystitis with alkaline secretion, and phosphates were thus deposited on the hair. There were thirty-one small stones, each formed in the same manner, at the end of a hair.

Dr. Charles H. Chetwood presented two specimens of vesical calculi which he thought of special interest in connection with the general consideration of the subject of Dr. Keyes. The first specimen presented had been removed from a 3-year-old child about a week previously in the clinic. The size and compactness of the specimens were such that he thought it



probably a fetal formation. The diagnosis was made with a silver probe, with which he touched the stone without difficulty. A suprapubic incision was made and the stone removed. It weighed 5.44 grammes. The patient has a suprapubic fistula, which the speaker thought would heal in a few weeks. The other stone formed upon a broken-off catheter, and was removed from a patient 72 years old who had an enlarged prostate. It weighed 10.44 grammes and was composed of a triple phosphate and ammonium urate. The catheter nucleus was broken off in the bladder some three years before the calculus was removed.

#### CYSTIN CALCULUS.

Dr. Manges showed a cystin calculus which he thought particularly interesting because there are probably not more than fifteen specimens in the entire world. The stone, which weighed fifty grains, was passed spontaneously by a boy 20 years of age. The patient disappeared, so that no chemical analysis could be made. These stones are closely associated with a putrefaction which goes on in the intestines and are excreted in the urine as well. This disease often occurs in families, but the chemical analysis is unknown.

Dr. Manges showed two specimens of renal calculus, and the kidneys from which they had been taken. A patient who was operated on for the relief of difficulty in secretion of urine died, and upon examination it was found that extreme atrophy of the kidney had resulted from the impaction of a stone in that organ.

The second specimen was a very good demonstration of the stone in situ. A very large kidney had been packed with stone, which had in time caused a hydronephritis. At the lower end of the specimen, part of the kidney could be seen beyond the pelvis, showing what extensive changes may be produced by the long residence of stone in the kidney.

#### "X"-RAY DEMONSTRATION OF STONE IN THE URETHRA.

Dr. Albert Kohn presented an X-ray photograph of a patient who had suffered from attacks of colic for fifteen years. His symptoms were relieved by hypodermic injections of morphine. After one of these attacks he had a chill, and the

diagnosis of "surgical kidney" was made and a surgeon called. The patient was removed to a hospital, where he could be watched for confirmation of the diagnosis, and three days afterward he developed a second attack and one week later a third attack. An exploratory incision was made into the kidney, and no stone was found, but there was an acute infection. This wound was barely healed when the patient had another attack of colic, followed by a chill. The surgeon went in from below and catheterized the ureter and found what he thought was a stricture. The patient was sent to have an X-ray photograph taken and fortunately the stone lay directly in line with the photograph. The surgeon cut down on the ureter and removed the stone.

#### RENAL CALCULUS.

Dr. J. Riddle Goffe presented a specimen of renal calculus removed by him from a woman aged 40 years, who was sent to him for operation for ovarian cyst. She had suffered from severe pain, from chills and fever, for about six months, and was treated for malaria. Her urine had been examined several times and no pus had been found. Upon examination it was found that she had a large tumor, which had no connection with the pain, and upon opening the kidney a large stone was discovered, which blocked the passage. It was removed without difficulty and without opening the ureter.

The speaker said that the specimens of calculus growing upon the end of a hair, shown by Dr. Keyes, recalled to his mind a patient, female, aged 45 years, who, several times a year, plucked tufts of gray hair from her anus. It always reappeared in a few months. She had a tumor, and on operating a large dermoid cyst was found, and over the pelvis it had lacerated through the rectum and the rectum had closed around it. This was the origin of the tufts of hair.

Dr. F. M. Jeffries said it is impossible to give a definite explanation of the etiological factors in the formation of these calculi. A number of theories have been advanced. One thing is certain, three factors must be present before calculi can be formed; first, the chemical constituents of the urine; second, nidus; third, a substance capable of entering into and making a stroma. It is true that two substances at least manifest in themselves a cohesive power, as seen in the uric acid of roseate

crystals and in calcium oxalate, where the crystals are found in rare spherical and dumb-bell shapes. The reaction of the urine will control the kind and variety of stone that is formed, an acid urine allowing only those to form that are insoluble in the acid, and an alkaline urine causing those that are insoluble in alkaline fluids. As regards the nidus, Dr. Keyes had shown a number of specimens in which it was crystal; what forms on that afterward depends on what takes place in the bladder. One substance which Dr. Keyes did not mention, which is sometimes found forming the nidus, is a blood clot. A peculiar feature regarding the formation of calculi is that they are particularly liable to occur in particular, definite, fixed localities, while territories in the close vicinity may leave their population comparatively free from this affliction. This led to a strong opinion that the variety of waters might have something to do with their formation, but investigations on this line have not thoroughly satisfied those who adhere to this theory.

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### A GENITO-URINARY SYMPOSIUM.

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Report in abstract of the regular monthly meeting of the Northwestern Branch  
of the Philadelphia County Medical Society, held March 10, 1904.  
Dr. Samuel Wolfe, President.

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#### LOCAL TREATMENT OF GONORRHOEIC INFECTIONS.

Dr. H. R. Loux read a paper entitled "The Local Treatment of Gonorrhoeic Infections."

Dr. Loux stated that, although a continuous service of eleven years in one of the largest genito-urinary clinics in America had afforded him unusual opportunities for observation, he had never written a paper upon the treatment of gonorrhea, because no method heretofore suggested proved, upon prolonged trial, to be an advance worthy of commendation. Clinical observation in thousands of cases convinced him that gonorrhoea is too often grossly mistreated. He deprecated the use of strong, irritating injections because they aggravate the disease and damage the urethra, and stated that treatment of acute anterior urethritis by irrigation is to be condemned because it causes an extension of the disease by continuity;

he quoted statistics, reasons and authoritative statements to show that these opinions represented the beliefs of the leading and most conservative genito-urinary surgeons.

The speaker stated that during the past year and a half the results at his clinic at the Jefferson Hospital and in private practice, had been much better than ever before; this statement he based upon the observation of several thousand cases of gonorrhea at all stages. The reasons for this improvement he ascribed to careful local treatment in which he abandoned, absolutely, the use of any drug as an injection which can cause the slightest irritation. Dr. Loux stated that, in a general way, his methods of treatment were as follows: For acute gonorrhea, he prescribes light diet, with very little meat, no fats, fruit or alcoholic beverages, but allows as much skimmed milk as the patient can drink. If the infection is confined to the anterior urethra, he prescribed the injection of two drachms of a 10 per cent. solution of argyrol, held in the urethra ten minutes; this injection is made in the morning, at noon and at night. Internally, he prescribes capsules of copaiba, cubeb and sandalwood three times daily. This treatment is practiced for one week, during which time the discharge will almost if not entirely cease, there will be no pain or irritation by the injection or upon urination, and the gonococci will disappear.

If, at the end of one week, the urine remains continuously shreddy, a weak solution of astringents is employed and of these drugs he preferred zinc sulphate, iodide, chloride, hydrastin or berberine muriate, but emphasized that these astringents should not be used during the first week of the disease and never in solutions sufficiently strong to produce pain or irritation.

If the two glass test shows cloudy first and second portions of the urine, showing the presence of antero-posterior urethritis, he irrigates the anterior urethra with a warm solution of boracic acid in order to remove the accumulated secretions. Then he makes deep instillations of 20 per cent. argyrol solutions once daily or on alternate days; the inflammation of the anterior urethra is treated in the manner already described.

The writer quoted from statistics of four hundred cases, treated since July, 1902, by the methods described, and stated the advantages as follows: Simplicity; the relief afforded the

patient from pain and irritation; the extreme rarity of complications; shortened duration of diseases, in that an average time required for cure in acute cases was twenty-one days, whereas by the older methods practiced at the clinic and in private work, the best average obtainable was forty-two days.

Dr. Loux then discussed the treatment of gonorrhea in the female, the methods of which are best described by an illustrative case: A. G., age 21, came under observation June 5, with acute vaginitis, endometritis and urethritis for which she had been under treatment in New York for one week. Typical symptoms of gonorrhoea were present; microscopical examination positive. The vagina was dilated to full extent by means of speculum. To every portion of the vaginal mucous membrane a 50 per cent. argyrol solution was applied, and the same to the urethra by means of a cotton-tipped probe. The interior of the uterus was then freed of accumulated secretions by means of a cotton-wrapped applicator, after which the 50 per cent. argyrol solution was applied to the cervix and the body of the uterus. These applications are repeated two or three times so as to fill the uterine cavity with the solution. This local treatment was carried out every second or third day. After eight days no gonococci could be found. For home treatment the patient was ordered vaginal douches of from two to four quarts of hot boracic acid or normal salt solutions taken in the recumbent posture. On June 20 there was no discharge or other symptoms of gonorrhoea and the patient was discharged. On June 29 she was attacked with acute appendicitis, for which he operated and removed a sloughing appendix. For the subsequent five weeks, during which she was in bed in the hospital recovering from the operation, he made observations every few days of her genito-urinary organs and there was no symptom of gonorrhoea. The patient made an uninterrupted recovery and left the hospital.

In discussing chronic conditions which result from a neglected or improperly treated gonorrhoea, Dr. Loux stated that care should be exercised in adapting methods and means to avoid irritating the already damaged urethral structures. He emphasized the necessity of making routine use of the endoscope and to determine the nature of the disease.

Chronic follicular urethritis is readily recognized by endoscopic examination and by palpation of the enlarged follicles over a bougie, and is treated by gradual dilatation of the urethra by means of bougies, massage of the enlarged follicles, and by the local application of 25 to 50 per cent. argyrol solution to the individual enlarged follicles as revealed by the endoscope. This treatment is carried out three or four times a week and is by far the most satisfactory method he had ever found.

Most cases of chronic gleet are due to ulcerative conditions of the urethra, and in the management of these the endoscope is indispensable. After determining the exact location of the individual ulcerations the method of treatment depends upon whether the ulcerations are sharply localized or whether there is a coexistent general hyperaemia of the urethra. In the former case, applications of 50 per cent. argyrol solution (through the endoscopic tube) to the ulcerations should be made at least three times a week. If general hyperaemia exists, the use of mild astringents should precede the topical application of argyrol, in order to rid the urethra of the mucopurulent accumulations. From four to six weeks of this treatment, with care in the use of instruments will heal the ulcerations and cure the gleet in the large majority of cases.

Another very common condition is the reduction in the lumen of the urethra by inflammatory exudate, occasioned by repeated attacks of gonorrhoea or a primary case of long duration. In these cases, endoscopic examination shows the seat of beginning stricture and the presence of more or less localized inflammation. The management of these cases is extremely important because of the certainty of the occurrence of organic stricture unless the patient agrees to a several weeks' course of treatment. He should report every third or fourth day for the passage of bougies of gradually increasing sizes, followed, if active inflammation exists, by the deep instillation or topical application of 25 per cent. argyrol solution, depending upon whether the inflammation is circumscribed or more or less diffuse.

Dr. Loux summarized his paper as follows: Concerning acute gonorrhoea: 1. He would strongly deprecate the treatment of acute anterior urethritis by means of irrigation, because of the danger of spreading the disease to the posterior



urethra. 2. Irritating injections of any kind should never be used in acute gonorrhoea because of the certainty of occurrence of a mixed infection and the extension of the disease, by contiguity, to the urethral follicles. 3. Argyrol, as a non-irritating gonococcide, with a specific effect in allaying the symptoms of inflammation, is the drug of choice for injection, and may be used in any strength and at any stage of the disease. 4. Astringents, such as zinc, hydrastin, bismuth and lead, should never be used in the acute stage of gonorrhoea, but should be reserved for the post-gonococcus period when the urine remains shreddy. 5. These astringents should not be used in sufficient strength to cause the patient to experience pain or irritation.

To summarize concerning chronic gonorrhoea: 1. Endoscopic diagnosis and treatment is indispensable as a routine measure. 2. Silver nitrate or other caustic or irritating applications or instillations should be seldom used, and then only in the most skilled hands and with the greatest care; otherwise there are likely to occur structural changes in the urethra, predisposing to organic affections amenable only to surgical procedures.

The discussion of Dr. Loux's paper was opened by Dr. H. M. Christian. Dr. Christian complimented Dr. Loux upon the excellence of the paper read and stated that the methods mentioned were, in the main, those practiced by himself. He stated that potassium permanganate is of no value in gonorrhoea other than as a simple cleansing agent. Dr. Christian agreed with Dr. Loux that argyrol was undoubtedly the best gonococcide known to-day. After having used that silver salt continuously for more than two years, he prefers it because it never irritates, it is rapidly destructive to the gonococci, lessens the discharge and shortens the duration of the disease.

The speaker stated that it must be borne in mind that we have to deal not only with the gonococci, but with the destructive action of the micro-organism as well; in other words, destruction of the gonococcus does not by any means imply of necessity the cure of the disease, as there always remains a condition of catarrhal urethritis which requires a particular line of treatment. If a case of gonorrhoea is seen in the early inflammatory stage, where ardor urinae and chordee are the most annoying subjective symptoms, Dr. Christian orders.

powders containing salol, sodium bromide, potassium bromide, each two and a half grains every two hours. At the same time a 5 per cent. solution of argyrol is ordered to be used by the patient as a hand injection three or four times daily, the solution being held in the urethra for ten minutes. If the patient can spare the time it is advisable to wash out the anterior urethra with several syringefuls of warm normal salt solution prior to using the argyrol injection; this line of treatment can be carried on through the second and third week. When the subjective symptoms subside, it is sometimes of considerable advantage to supplement the local treatment with the use internally of copaiba and sandalwood oil. Ordinarily at the beginning of the third week, the patient enters upon the stage of decline, or, as Prof. Finger styles it, the "mucous terminal stage" of the disease. In a case going on to recovery, the discharge is now scanty, then muco-purulent in character and containing few if any gonococci, and this is by far the most important stage in the treatment of the disease as regards the patient's future welfare; it is here that experience teaches that we need more than a mere gonocidal agent. We need here in addition mild astringent lotions to help restore the integrity of the damaged mucous membrane. A good plan now is to use 5 per cent. solution of argyrol night and morning, employing through the day some such astringents as zinc, bismuth, hydrastin, lead, berberine, etc. At the beginning of the fifth week when nothing remains but the well-known "morning drop" and the urine is clear but contains shreds, it is well to use the argyrol solution at night and to use once or twice through the day one of the well-known astringent mixtures.

If in the second or third week the clinical symptoms and the two-glass test show involvement of the whole urethra, the treatment by hand injections is temporarily abandoned. Deep instillations of 10 per cent. solutions of argyrol are then employed at short intervals until such time as the second urine becomes clear.

This in general is the line of treatment that the speaker had used at the University of Pennsylvania and his other clinics for the past two years and is one that has given more satisfactory results than any hitherto employed.

Dr. Orville Horwitz condemned the irrigation treatment of gonorrhoea and summarized his opinions as follows: The



irrigation method of treatment will not abort acute specific urethritis; chronic urethritis and involvement of the deep sexual organs are common sequences; in many instances, in order to effect a cure in the terminal stage of the disease, the irrigation must be discontinued and other methods of treatment employed; irrigation should not be employed in the acute stage of specific urethritis; irrigation of the deep urethra by means of hydrostatic pressure is injurious in the majority of cases of acute gonorrhoea, and is conducive to the development of complications; the best treatment we have to-day for gonorrhoea is that by means of injection of argyrol solutions which are strongly antiseptic and non-irritating.

Dr. R. O. Kevin prefaced his remarks with the statement of the French surgeon, Ricord, that "A clap begins and God alone knows when it will end." Fortunately, however, this statement is not as true as it was a few years ago. Dr. Kevin stated that with the use of 20 per cent. argyrol solution he had been able to cure 85 per cent. of his acute cases in from two to four weeks. He quoted Purdy, of London, who stated that since the introduction of argyrol into the enormous clinic at the London Lock Hospital, 72 per cent. of the early cases had been cured within a month and there had been no relapses after six weeks. Dr. Kevin had been associated with Dr. Loux for several years at the clinic and could corroborate his conclusions. The speaker stated that he had seen so many acute cases cut short that he always practiced the abortive method when possible; this method is as follows: If the patient presents himself during the first forty-eight hours of an attack of gonorrhoea, the anterior urethra is washed out with warm water or normal salt solution. Then two drachms of 20 per cent. argyrol solution is injected into the anterior urethra and held there for ten minutes; this injection is repeated by the patient every three hours, night and day, for three days. Even if this method does not abort the disease, it always effects a cure in a shortened period, and affords the patient entire freedom from the pain and irritation usually present in an early gonorrhoea. If by this means the disease does not show signs of being aborted, Dr. Kevin practices the same methods mentioned by Dr. Loux.

## SENILE PROSTATIC HYPERTROPHY.

Dr. Orville Horwitz read a paper entitled "The Radical Cure of Senile Hypertrophy of the Prostate; based upon a study of 145 operations performed by the author."

Dr. Horwitz stated that the question under discussion has, with the possible exception of appendicitis, attracted more attention in the surgical world than any other subject. It is well recognized that the danger to the patient with enlarged prostate begins as soon as it is necessary to resort to the daily use of the catheter and when this period arrives a surgeon should be consulted to supervise the case and decide what operative measures are desirable or necessary. It was emphasized that no one operation was suitable to all cases and that each patient is a law unto himself in the matter of choice of operation.

The two operations which have stood the test of experience are prostatotomy by means of the galvano-cautery (the so-called Bottini operation) and prostatectomy. The speaker stated that the Bottini operation is extremely valuable, safe and always to be preferred to cutting operations in suitable cases. Out of 98 cases operated upon by the author, by the Bottini method, three died, two of uraemia, and one of sepsis; all three were very old men. Twelve cases were lost sight of after leaving the hospital but were much improved when last examined. This leaves 81 cases concerning which there was obtained definite knowledge as to results. The ages of the patients varied between 52 and 81 years. The speaker stated that his statistics proved conclusively that the earlier the patient submitted to operation, the better the results. Of the total 81 Bottini operations all the patients were either entirely cured or very much benefited; four required second operation, and a considerable proportion were treated for several months subsequently for accompanying chronic cystitis.

Prostatectomy, the speaker stated, is regarded as a valuable operation but authorities differ as to when and how it is to be performed. As many as twenty different operations have been suggested. Here, too, the individual case decides methods, choice of operation, etc. The prostatectomies performed by the author were as follows: Three complete (suprapubic incision); 6 complete (combined suprapubic and perineal incisions); 7 partial prostatectomies (suprapubic incision); 34 complete perineal prostatectomies.

Of the nine complete suprapubic operations, two died, one of suppression of urine, one of uraemia. In all the cases convalescence was slow; in five cases the ultimate results were all that could be desired.

Of the thirty-four perineal prostatectomies, six died from uremia, sepsis or shock; six cases were lost sight of after leaving the hospital; sixteen were cured, four markedly benefited, one unimproved.

Dr. Horwitz summarized the results of observations in his 145 operations as follows:

1. A routine method is not applicable to the treatment of prostatic hypertrophy; every case is a law unto itself and the treatment will depend on the various conditions presented in each individual case.
2. The dangers attendant on the daily catheterism are greater than those of a radical operation performed at the onset of the symptoms caused by the obstruction.
3. The proper time to perform a radical operation is reached as soon as it becomes necessary for a patient to resort to daily catheterism.
4. The gratifying results obtained by a number of the operations in many cases demonstrates that the Bottini operation is one of great surgical value. It is applicable to a large percentage of cases; which if properly selected has proved to be the safest and best method of relieving an obstruction caused by prostatic hypertrophy. In those cases in which a stone in the bladder is associated with a prostatic enlargement, lithopaxy may be performed in conjunction with a galvano-cautery prostatotomy.
5. A complete prostatectomy is justifiable if performed early before the individual is broken down in health and secondary complications have supervened. In early operation the results are most satisfactory, recovery rapid, the mortality between 5 per cent. and 7 per cent.
6. A complete prostatectomy in feeble elderly patients with long-standing obstruction and secondary complication, the prognosis is grave and the mortality ranges between 15 per cent. and 18 per cent. If the bladder in these cases happens to be hopelessly disabled, the results obtained by the operation are negative. Cases of this description are only suitable for suprapubic drainage.

7. In 90 per cent. of all cases the gland can be readily removed by means of a median perineal incision. The perineal operation recommended by Bryson is considered the operation of choice.

8. Complete suprapubic prostatectomy is shown to be more dangerous than the perineal operation for obvious reasons. A suprapubic prostatectomy is safer if combined with perineal drainage.

9. Partial suprapubic prostatectomy is indicated in such cases as where a valve-like lobe exists which interferes with urination, or where there is a partial hypertrophy of one of the lobes.

10. A perineal prostatectomy is best suited for those cases where the enlargement of the lateral lobes has a tendency to progress towards the rectum, to obstruct the urethra, or project backwards into the bladder.

11. A prostatectomy is always attended with more danger than the Bottini operation and the convalescence is more prolonged. In suitable cases the latter operation is therefore the one of choice.

Dr. Edward Martin discussed the preceding paper as follows:

He agreed with Dr. Horwitz that, if operation has been advised and consented to, the circumstances of the individual case decided which of the several operations is to be performed. He believed that the Bottini operation has proved of great value and is preferable to cutting operations in suitable cases. He did not, however, advise operation in all cases of enlarged prostate. He recognized the inconveniences and dangers attendant upon the daily use of the catheter, but believed in the value of palliative measures in the majority of cases. He recommended care in the selection of catheters and one that enters the bladder with the least force and least pain to the patient. If a soft rubber catheter cannot be introduced, a woven elbowed one is to be chosen. If obstruction or spasm necessitates habitual resort to a metal catheter, surgical intervention is required. When patients use the instrument upon themselves, the hands should be washed thoroughly, dipped in bichloride solution, the meatus washed with the same solution, and be provided with an irrigating bag containing one pint of hot argyrol solution, 1 to 1,000. In-

fection of the bladder is commonly present and should be treated by means of bladder irrigations. For this purpose a fountain syringe, supplied with a catheter, should be suspended two feet above the level of the bladder. The anterior urethra is first thoroughly flushed, after which the catheter is pushed into the bladder and the urine withdrawn. The flushing of the bladder is continued until the return flow no longer contains pus or mucus. The temperature of the argyrol solution employed should be of the temperature of the body or a little above it. When practicable this antiseptic flushing should be done each time the catheter is passed. If this treatment is inefficacious continuous catheterization becomes necessary. For this purpose a large soft rubber catheter, or a self-retaining one, is selected and the antiseptic solution introduced; if the catheter is properly introduced, the entire amount of the solution will return. Twice a day the urethra and bladder are thoroughly flushed with the antiseptic solution, the catheter being withdrawn far enough to allow the injected fluid to escape from the meatus, and then being pushed back into its former position.

The success of this treatment depends upon securing free and continuous drainage and this is incident to the permeability of the catheter and its retention in the proper position. When skillfully applied it is one of the safest and most successful means of treating cystitis, which so frequently complicates obstruction from prostatic enlargement.

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## *Records, Recollections and Reminiscences.*

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### OUR NEXT REUNION.

The next annual reunion U. C. V. will be held in the city of Nashville, Tenn., and the dates definitely decided upon, June 14, 15 and 16, will witness a larger gathering of the "Boys who wore the gray" than has been assembled since those trying days when they strove, struggled and starved for that which they believed to be right. While the Capital City of the Volunteer State is not so large as some that have entertained this heroic host, yet the hearts and hospitality of her citizens

are as large as any. The reunion held here before has been most favorably remembered by all who were present, and the "pace was set" that others have endeavored to maintain. Well, this year the same efforts, energies just as sincere, and efforts not one whit diminished will again be the order of the day with every citizen within her gates.

Its central location, the early summer days, her progressive and determined spirit in behalf of the future, and her recollection of those sad days of the past, the friendly home-like manner of her treatment of all visitors, will combine to give all who may come a welcome, yes, a welcome that will long be remembered.

More than ordinary delay this year in determining where the reunion should be held, and a change of date from that first selected by the committee having this matter in charge, will have no effect in the manner and character of the entertainment. A general committee of thirty, composed of ten members of the Chamber of Commerce, ten from the Retail Merchants' Association and ten from Frank Cheatham Bivouac will have entire control of the city from Tuesday, June 14, until the last day of the occasion, which will be made the grandest in all the eventful history of this city.

The general committee will hold weekly meetings until the week of the reunion, and the sub-committees will meet as often as may be required. The following well-known citizens constitute the general committee: Chas. F. Frizzell, Chairman; I. C. Garrabrant, Vice Chairman; Joseph Frank, Treasurer; L. R. Eastman, Secretary; Dr. J. R. Buist, H. W. Buttorff, W. C. Collier, Lee Cantrell, W. J. Cummins, Capt. M. S. Cockrill, S. A. Cunningham, C. H. Eastman, E. C. Faircloth, Edgar M. Foster, W. D. Gale, Thomas C. Hindman, Humphrey Hardison, Eugene O. Harris, Leland Hume, C. R. Handley, George Holle, Capt. George F. Hager, Capt. I. J. Howlett, Col. John P. Hickman, Capt. John W. Morton, Charles Mitchell, Jr., Dr. W. J. McMurray, Lawrence G. O'Bryan, Jesse M. Overton, Capt. M. B. Pilcher, Col. George C. Porter, W. P. Rutland, James B. Richardson, P. A. Shelton, Maj. John W. Thomas, Oliver J. Timothy, M. B. Toney, Maj. T. P. Weakley, J. Mat Williams.

Various sub-committees composed of the members of the general committee, largely reinforced by other citizens of Nashville have been appointed, and the details of the work is

now being actively carried on. At the last meeting of the general committee, held prior to this writing (18th inst.), the sub-committee on finance reported that over half the amount needed had been subscribed in the less than one week of work, and not one half of the districts had been canvassed. The committee on commissary, under charge of Dr. W. J. McMurray, who had this matter in charge at our last reunion, reported most excellent progress in the brief and limited canvass that had been made.

As a matter of interest to many of our readers, even at this date, nearly two months before the reunion, we give in full as at present constituted, the committee on homes: Leland Hume, Chairman; E. O. Harris, Lee Cantrell, I. J. Howlett, C. H. Eastman, George Holle and George F. Hager, whose duties are "to secure homes for visitors, especially for veterans; to arrange for hotel rates, and in conjunction with the publicity committee to advertise hotel and boarding-house rates for visitors." Now, do not hesitate to write to any member of this committee if you desire to secure quarters before coming. We have not given the street number of these gentlemen, for this is not necessary, as our postoffice people know each and all of them well, as well as every member of the general committee, and any communication addressed to anyone of them at Nashville, Tenn., will be promptly delivered by the "boys who now wear the gray."

The Association of Medical Officers of the army and navy of the Confederacy will hold its annual meeting this year as before, in conjunction with the reunion. That they will be amply and well provided for goes without saying. In our next issue we will be able to go more fully into details as to them. At this time all we desire to say is we hope that every one who has attended a previous reunion and every one who can will use his utmost endeavor to be on hand. Yes, come along, every one of you, and bring your wives, your children and their children. Nashville will take care of you, and her people will feel honored in so doing.

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A MOST VALUABLE REMEDY in conditions attended with malnutrition, general debility, and nervous exhaustion is Gray's Glycerine Tonic Comp. Its reputation is based upon twenty years' successes in cases unbenefited by other treatment. In convalescence from "grip" it is a most valuable "pick me up."



### CONFEDERATE BATTLE FLAGS.

At the request of Dr. Samuel E. Lewis, of Washington, D. C., we place before our readers the following special order of our late Commander, Gen. John B. Gordon:

Headquarters United Confederate Veterans, New Orleans, La., Jan. 9, 1904.—Special Order No. 23.

1. The General Commanding takes great pleasure in complying with the request contained in the subjoined communication from the Finance and Executive Committee:

Louisville, Ky., Nov. 19, 1903.—Maj. Gen. Wm. E. Mickle, Adjutant General and Chief of Staff, New Orleans, La.—General: I beg to notify you officially of the action of the Executive Committee at the recent meeting held in this city, with reference to the Confederate battle flags, and to request that the special committee suggested be appointed by the Commanding General, and the necessary orders be issued in regard thereto.

For a number of years past the battle flags manufactured, displayed and offered for sale have not found favor with the veterans for the reason that these latter-day flags were not correct reproductions of the battle flag as designed and used by the Confederate armies, these flags being oblong instead of square, the correct shape. This misrepresentation is perpetuated in the publication issued by the United States Government known as the "Official Records of the Union and Confederate Armies," where there are what purports to be accurate reproductions of the various flags. The proportions of the stars and bars and the later Confederate national flags seem to be correct, but the battle flag is wrong. This erroneous publication has caused all manufacturers to put on the market an oblong flag, and none other can be obtained without an especial order and enormous expense. This so impressed Dr. Samuel E. Lewis, the member of the Executive Committee from the Division of the District of Columbia that he began an investigation, which he has prosecuted with unwearied persistency; and at the meeting above mentioned, he offered the following resolutions, which were unanimously adopted:

Whereas, There appears much difference of opinion as to the shape and design of the battle flag of the Confederacy, a mat-

ter of such historical importance as to require settlement in authentic manner by the veterans now living; therefore, be it

Resolved, That a committee of five be selected to ascertain all acceptable data regarding the origin, shape and design of the same, and prepare a resolution to be submitted for consideration by the United Confederate Veterans to be assembled in convention at the annual reunion to be held in Nashville, Tenn., in 1904.

And further, that said committee is also hereby directed to ascertain the laws of the Confederate Congress relating to the afore-mentioned battle flag and the flags adopted respectively on March 4, 1861, and May 1, 1863, and March 4, 1865.

The Chairman thereupon named the following as the committee: Samuel E. Lewis, M. D., Washington, D. C., Chairman; Col. Fred. L. Robertson, Tallahassee, Fla.; Brig. Gen. J. F. Shipp, Chattanooga, Tenn.; Col. J. Taylor Ellyson, Richmond, Va.; Gen. A. C. Trippe, Baltimore, Md. Fraternally,

W. A. MONTGOMERY, Chairman.

FRED. L. ROBERTSON, Secretary.

2. The Commanding General hereby orders that this committee at once set about gathering the information desired, and that due diligence be used to obtain all the facts in existence, so that the utterance of the Nashville convention on this subject may be final.

3. If there be time to undertake the additional labor, the Commanding General instructs the committee to secure all possible information as to the State, naval and other flags carried by regiments or companies, or flown at sea and on the coast during the war between the States. By command of

J. B. GORDON, General Commanding.

Official: WM. E. MICKLE,

Adjutant General and Chief of Staff.

Note—Address communications to Samuel E. Lewis, M. D., No. 1418 Fourteenth Street, N. W., Washington, D. C.

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GENITO-URINARY TONIC.—W. B. Buckley, M.D., National Home, Milwaukee County, Wis., late Assistant Surgeon, United States Army, says: "I have tried, with excellent results, your valued preparation, SATYRIA, and was much pleased with its results. I am convinced of its great worth as a genito-urinary tonic, and wish you deserved success."

## *Editorial.*

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### PRELIMINARY PROGRAMME.

The Seventy-first Annual Session of the Tennessee State Medical Association will be held in Chattanooga, Tenn., at the Read House, April 12th, 13th, and 14th, 1904.

Opening with Prayer.

Address of Welcome.

Response to Same.

Medical Organization, by J. N. McCormack, M. D., LL. D., Secretary Kentucky State Board of Health, of Bowling Green, Ky.

Membranous Croup, with Report of Cases, by J. T. Herron, M. D.; of Jackson.

Diphtheria, with a Resume of Cases treated with Antitoxin, by J. B. Witherington, of Munford.

LaGrippe and its Complications, by A. J. Swaney, M. D., of Gallatin.

Brain Abscess, by W. A. Bryan, M. D. of Nashville.

Therapeutic Treatment of Phthisis, by Rufus Pitts, M. D., of Murfreesboro.

Therapy of Sodium Chloride, by J. S. Nowlin, M. D., of Shelbyville.

Irrigation—Its Therapeutic Application, by E. P. Vaughan, M. D., of Manchester.

The Therapeutic Application of Light, by G. P. Edwards, M. D., of Nashville.

### SYMPOSIUM OF PNEUMONIA.

Special Order for the Morning of the Second Day.

I. Louis LeRoy, of Nashville, Bacteriology and Pathology of Pneumonia.

II. Jno. A. Witherspoon, M. D., of Nashville, Early Diagnosis and Semiology of Pneumonia.

III. E. G. Wood, M. D., of Nashville, Medicinal Treatment of Pneumonia.

IV. E. A. Cobleigh, M. D., of Chattanooga, Local or External Treatment of Pneumonia.

V. Jno. S. Cain, M. D., of Nashville, Bloodletting in Pneumonia.

VI. Jas. B. Murfree, Jr., M. D., of Murfreesboro, The Heart in Pneumonia.

Renal Surgery, by Richard Douglas, M. D., of Nashville.

The Surgical Treatment of Bright's Disease, with Report of a Case, by M. Goltman, M. D., of Memphis.

Surgery of the Hand, by Paul F. Eve, M. D., of Nashville.

Tetanus, by J. T. Happel, M. D., of Trenton.

Visual Inspection of Railway Employees, by C. M. Capps, M. D., of Knoxville.

Operation for, and Specimen of (a), Gall Stone in Common Duct; (b), Cancer of Umbilicus; (c), Cyst of Kidney; (d), Fibro-Myoma of Uterus; (e), Tubercular Ostitis of Femur, by W. D. Haggard, Jr. M. D., of Nashville.

After Treatment of Abdominal Section, by Lucius E. Burch, M. D., of Nashville.

Some Anomalies of Chronic Appendicitis, by Jno. A. Gaines, M. D., of Nashville.

Sanitary Advances, E. H. Jones, M. D., of Murfreesboro.

Typhoid Prophylaxis, by H. C. Chance, M. D., of Cumberland Gap.

Leucocytes in Typhoid Fever, by Wm. Litterer, of Nashville.

Internal Antisepsis in Typhoid Fever, by J. A. Crook, M. D., of Jackson.

Inflammation and Ulceration of the Pelvic Colon, by F. B. Reagor, M. D., of Shelbyville.

Chronic Dysentery—A Protest, by A. B. Cooke, M. D., of Nashville.

The Microscope in Diagnosis, by W. P. King, M. D., of Lutts.

The Present Status of the Etiology and Pathology of Malignant Growths, by Raymond Wallace, M. D., of Chattanooga.

Hydrostatic Test for Infanticide, by J. R. Gillespie, M. D., of Dayton.

Hysteria, by J. W. McQuillan, M. D., of Chattanooga.

Fractures of the Elbow Joint, by J. B. Murfree, Sr., M. D., of Murfreesboro.

Fractures in the New Born, by G. C. Trawick, M. D., of Nashville.

Some Causes of Error in Pulmonary Diagnosis, and their Explanation, by C. P. McNabb, M. D., of Knoxville.

The General Practitioner's Relation to Insanity and Its Management, by M. Campbell, M. D., of Eastern Hospital for Insane (Lyon's View), Knoxville.

Local Anesthesia—Holocain, by Frank Trester Smith, M. D., of Chattanooga.

Duty of the Profession in Reference to So-called Medical and Religious Subjects, by Y. L. Abernathy, M. D., of Chattanooga.

Venereal Diseases and the Social Order, by Otey J. Porter, M.D., of Columbia.

Rheumatoid Arthritis, with Report of Case, by David R. Neil, M.D., of Nashville.

Treatment of Puerperal Sepsis, by J. T. Altman, M.D., of Nashville.

Early Diagnosis and Treatment of Otitis Media, by N. C. Steele, M.D., of Chattanooga.

Honesty and Ethics, by Jno. M. Kennedy, M. D., of Knoxville.

ANNUAL ADDRESS of the President, I. A. McSwain, M. D., of Paris

— The Science of Medicine the Science of Humanity. This will be made the special order for the night session of Tuesday, and being of a general and popular character, the Public will be cordially invited to attend.

A number of other Papers will be presented at the meeting, of this we may feel well assured.

Read the program and see if there is not something in it that will interest you. Come to the meeting and add to the interest of the occasion by offering such discussion, on one or more of the subjects, as will be helpful to your fellows. Encourage other members of your County Society to attend.

Between now and the meeting, induce one or more of your neighboring physicians to join your County Society, unless all are now members. "*A Society in every County and every reputable physician in the county a member*" should be inscribed on our "Medical Banner." At Chattanooga, new names can be added to your secretary's report.

Is there a County Medical Society in all of your adjacent counties? If not, why may you not become a medical missionary to the extent of going over to help them, without waiting for the Macedonian cry? Societies organized as late as the first week in April can be represented at the Chattanooga meeting.

Come to the meeting and bring others; add to the membership of your County Society; help to organize one or more new County Societies. Membership in your county Society makes you a member of the State Association, and eligible to the American Medical Association.

The Read House will be headquarters during the meeting, and Mr. Read has placed the banquet hall of that hotel at our disposal for the general meetings, and the ballroom for the sessions of the House of Delegates. At these halls everything will be convenient and agreeable.

The Read House is on the European plan, with rooms at from one dollar per day up. You can have your room there and take your meals elsewhere if you so desire; but the café and grill rooms are run in the best style and order. The Southern is on the American plan at two dollars to three dollars per day; the Stanton at two dollars and a half to four dollars per day, American plan, and one dollar and a half to four dollars per day European plan. The Rossmore, Russel, Northern, Almeda, are all small hotels, but neat, nice, and cheap.

Concessions in the way of fare to the mountain and back will be given, also to Chickamauga Park, new army post, etc., for those who wish to visit these interesting and historic places.

#### RAIL ROAD RATES:—

Persons paying full fare going to the meeting and who procure certificates of the standard form, properly executed and stamped by the agent at the starting point, will be sold tickets for the return trip at one-third of the first class fare, plus 25c, via the route traveled in going to the meeting.

See that you get certificates. If a through ticket can not be procured at the starting point, purchase ticket to the most convenient point at which such ticket can be obtained, and there get ticket through, securing certificate from each agent from whom ticket is procured, all these certificates to be presented to the special agent at the place of meeting, whose locality will be readily ascertained. Do not delay in getting your return ticket until the last moment before the meeting closes. Get this attended to at once on reaching the place of meeting.

I. A. MCSWAIN. M. D., *President.*

DEERING J. ROBERTS, M. D., *Secretary.*

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#### THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

This splendid Association that has shown such valuable work in the advancement of medical science and the extension of medical knowledge, second only in importance to the American Medical Association, will doubtless soon become a branch of the National Association, as indicated by a letter from its active and efficient Secretary, Dr. Henry E. Tuley, of Louisville, Ky. From it we quote:

"At the last meeting of the Mississippi Valley Medical Association, in Memphis, its Constitution was revised to conform to the requirements of the American Medical Association, looking to an affiliation with the latter as one of its district branches, action upon our application to be taken at Atlantic City next June, with every prospect of a favorable vote, as the Committee on Promotion has recommended that we be admitted.

"Believing, then, that we will be a branch of the American Medical Association at our next meeting in Cincinnati and operating under the new Constitution, it will be necessary for each of the component societies to appoint two of its members to represent their Association in the House of Delegates. Hence I would appreciate it if you will bear this in mind and have the President of your Association to appoint two of your members as delegates and present their names to me for record as soon after your next meeting as possible."

Accompanying the communication was a copy of the new Constitution and By-laws, from which the following points are gathered:

Component societies shall consist of the Missouri, Minnesota, Iowa, Arkansas, Louisiana, Wisconsin, Illinois, Kentucky, Tennessee, Mississippi, Michigan, Indiana, Ohio, Alabama, Georgia, and North Carolina State Medical Associations.

The Association will be organized on the practical plan of the National and State Associations, consisting of Members, Delegates, Honorary Members, and Guests.

To the House of Delegates will be entrusted the legislative func-

tions, leaving the General Sessions for scientific work exclusively. The former will be composed of two delegates selected by each State Association, and, *ex officio*, the officers of the Association.

The Association shall hold at least one annual session, at a time and place selected by the House of Delegates, with not less than two General Sessions each day, which shall be open to all Registered Members, Honorary Members, Delegates, and Guests.

Amendments to the Constitution and By-laws, Assessments and Expenditures, and a "Referendum" are provided for, as well as all other matters necessary in a practical, well-regulated organization.

This is as it should be. We have never affiliated with, or applied for membership in, the Mississippi Valley Medical Association, as much as we approved its truly valuable work, although at its meeting in this city we had the honor to serve as Chairman of its Committee on Exhibits, and received the warmest commendation from both members and exhibitors for one of the best-arranged exhibits in the history of medical meetings. Our objections were on the ground of there being too many organizations and favoring a concentration of energies in fewer, but stronger, organizations.

As the Mississippi Valley Medical Association formerly stood, it was independent of, and had no connection with, the National or State Associations, although members of it were also members of both the others. Now, to get within the portals of this branch, it is essential to be a member of your State Association, and this requires membership in your County Medical Society. This is practical and thorough organization—an organization with a correct basis, or foundation. It is bringing the profession closer together in one harmonious whole.

We sincerely hope to see at an early date the organization of other branches in other sections of the United States—all subordinate to, and a part of, the National Association; and as a member of our home County Society, of our State Association, and of the National Association, we will feel it a duty to add our humble efforts, in so far as lies within our power, to aid the best interests of this important branch.

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#### AS TO SUBSCRIPTIONS.

Having made it a rule for the past twenty-five years never to impose upon those of our readers who "promptly pay the printer" with matter intended solely for those who are on the other side of the fence in this respect, it is with pardonable pride that in this pleasant "spring-tide," when all Nature, both vegetable and animal—even the very rabbits, with their abbreviated narratives—is springing into life, we indulge in a few remarks, induced thereto by the following brief note, which we take the liberty of placing before our readers, stating that this particularly good Dollar was among the first to place his name on our subscription list a quarter of a century ago, his first subscrip-



tion commencing with the month of March. He has never waited for us to notify specially him that his subscription has expired, noting the exact time each successive year so plainly indicated on the outside of the mailing wrapper. Each successive year his renewals have come around as regularly as the bright spring days. We have other friends of the same method and manner, but yet there are others! The "Double William" enclosed was one of Uncle Sam's crispest, brightest, rivaling in its brilliant, verdant hue our own grassy knolls and vales. It was such as would gain nothing by our friend and representative Gaines' bill recently introduced in the House of Representatives, at Washington. O, no; there are no bugs on it, as we know there can be no flies on our very good Dollar at Gauze, Texas, whose note reads as follows:

"GAUZE, TEXAS, March 17, 1904.

"Deering J. Roberts, M.D., Nashville, Tenn.

"DEAR SIR: Enclosed please find two dollars to pay my subscription to THE SOUTHERN PRACTITIONER until March, 1906, and oblige,

"Very truly yours, J. M. DOLLAR, M.D."

Yes, as Punch would say: "That's the way to do it!"

As above stated, there are others like him; and then, again, there are yet others. Of the first class—I might say the "Dollar" class—some years ago a subscriber, also residing in the great empire of Texas, sent us his check for ten dollars. On sending him a receipt, we, after thanking him kindly, stated that we were not in the insurance business, only publishing a medical journal, and that while we could safely say that THE SOUTHERN PRACTITIONER, being firmly and soundly established, would undoubtedly be sent to all paying subscribers for far longer than ten years, even though we should have "shuffled off our mortal coil," yet if the same fate met him before the date of subscription was out, we did not think that we could reach him, even through the Dead Letter Department of our very efficient mail service. Well, the ten years has run out, and he is taking the risk on another decade. Three others—two in this State and one in Kentucky—have been taking out five-year policies; and quite a number are going on the "till-forbid" plan, only requiring us to send a sight draft each year. And—alas and alack!—yet, "Of all sad words of tongue or pen," "there are others!" "Verbum sapit." "A nod is as good as a wink to a blind horse."

#### OUR LOCAL MEDICAL AND DENTAL COLLEGES.

The medical schools of this city are nearing the close of the session of 1903-4, with most satisfactory and successful results. Notwithstanding the increased length of the terms, the attendance has been unusually large; and quite a number of well-equipped young medical practition-

ers will soon commence their active life work. In our next number we will be able to give a full report of the commencement exercises and lists of graduates.

There have been 154 students enrolled in the Medical Department of the University of Tennessee at and since the beginning of the present term. There are students attending the department from many of the Southern States; and one of the students is a Japanese, from Tokyo. The commencement exercises of the department will be held Monday night, April 4. Twenty-eight members compose the graduating class. The speech of the evening will be delivered by Joshua W. Caldwell, of Knoxville, who has been indorsed by the alumni of the university for the presidency to succeed Dr. Charles W. Dabney.

The commencement exercises of the Dental Department of the university will take place at Watkins Hall, May 2. There are 122 students attending this department. The graduating class is composed of 28 students.

Dr. Charles W. Dabney, president of the university, will preside over the exercises.

The exercises of the Medical Department of Vanderbilt University will take place on April 2, when degrees will be conferred on 39 graduates. The total number of students attending the department is 169.

The graduating exercises of the Dental Department of Vanderbilt University will take place on May 3.

At the commencement exercises of the Medical Department of the University of Nashville, which will be held on March 31, there will be 43 graduates. The degrees will be conferred by Chancellor Porter. C. P. McCall, of Georgia, will be valedictorian of the class.

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PENNSYLVANIA PRONOUNCES IT WHOLESOME.—Recently a direct effort was made to frame legislative measures which would presumably exclude Vin Mariani from sale in the State of Pennsylvania. The State Board of Health promptly took up the problem. The board employed two of the most prominent chemists of Philadelphia—namely, Professor Samuel P. Sadtler and Dr. F. A. Genth—who, after critical analyses of Vin Mariani, made from purchases of their own selection, failed to find pure cocaine in demonstrable quantity. This not only refutes the absurd falsity of suspicion that any alkaloid is surreptitiously added to the wine, but confirms, in the most convincing manner, the results of numerous former analyses made by the governments of France, Germany, Russia, and also in the United States. Each of these analyses admits the absolute purity of Vin Mariani as a preparation of true Coca leaves in a sound and nutritious French wine. As the Pennsylvania State Board of Health officially expresses it: "Vin Mariani is not a cocaine preparation, but a wine possessing the aromatic and desirable qualities of fresh Coca leaves."—*The Coca Leaf*, November, 1903.

**COCAINE IS NOT COCA.**—Vin Mariani was used by the profession fully twenty years before cocaine was known in medicine; in fact, through this preparation physicians were made familiar with the properties of Coca, and this was the original and only available form of employing the remedy. The popularity of Vin Mariani has led imitators to foist upon the profession artificial substitutes concocted by adding cocaine to wine. Such base frauds masquerading as "Coca Wine"—a title originated by M. Mariani—have done great evil and tend to unjustly cause condemnation of all Coca preparations as but false products.

Evils resulting from substitution and imitation of Vin Mariani and the abuse occasioned by these false concoctions have led to the introduction of State laws restricting the sale of cocaine and of cocaine preparations. Mariani & Co. are heartily in accord with such humane legislation, and, as manufacturers of the standard and original Coca Wine, urge official analysis of their preparation as testimony of the confidence reposed in them by the medical profession, who have long recognized the worth of Vin Mariani and who continue to prescribe it. It is but just to emphasize these truths and explain the difference between a true Coca Wine and base and dangerous impositions fortified by adding free cocaine.

**GONORRHEA.**—

R Satyria ..... 8 ounces

M. Sig. Teaspoonful three or four times a day after meals.

With the above, use an astringent injection as indicated.

**PASSIFLORA.**—Daniel's Conc. Tinc. Passiflora, Incarnata, calms and rejuvenates the whole nervous system. The most satisfactory results have been obtained from it in women's diseases, especially for the nervousness preceding and during childbirth. It allays irritation and all tendency toward hysteria, gives refreshing rest during the period of recuperation, and quickly restores the accustomed strength. Passiflora exerts a sedative influence upon the mucous surfaces of the entire urinary tract. As one physician expressed it: "Give Daniel's Passiflora regularly, as indicated, and leave the rest to Nature." This is the logical course to pursue, because Passiflora is Nature's remedy—prepared from the Maypop—and contains all the sedative and curative properties of this medicine-fruit.

**NEW ORLEANS POLYCLINIC.**—Sixteenth annual session opens November 2, 1903, and closes May 28, 1904.

Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory work.

For further information, address New Orleans Polyclinic, P. O. Box 797, New Orleans, La.

**ETHICS AND ART.**—From its introduction to the present day, Tyree's Antiseptic Powder has been purveyed only through strictly ethical channels. The formula has been freely published, of which fact certain unprincipled pharmacists have taken advantage. They have fostered the impression, in certain sections, that Tyree's Antiseptic Powder can be prepared extemporaneously for filling prescriptions.

Nothing could be more erroneous than this, since the manufacture of Tyree's Antiseptic Powder requires special apparatus, and a batch cannot be properly made in less than five days.

One hundred pounds each of borax and alum are fused together and dehydrated in a proper crucible. The resulting irregular masses are then ground to the desired degree of fineness in a special mill, the remaining ingredients added, and other special machinery utilized to secure uniform dissemination.

This elaborate chemical process determines, in a large measure, the phenomenal success attending the use of this powder. If a druggist had the requisite machinery, the time required by the process would be too long for routine prescription work.

Mortar and pestle cannot take the place of crucible, furnace, and special mills. Every effort at such substitution must, of necessity, invite inferior, if not injurious, clinical results.

To insure uniformly excellent results, always specify very plainly Tyree's; and, whenever possible, utilize only original packages.

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**A GOOD HEPATIC STIMULANT.**—When the hepatic cells themselves become atrophic and lose their nerve tonicity and refuse to respond to Nature's mandate of secreting bile, then we have a group of symptoms not unlike those of a diabetic, but the results of which would be quite different. In this condition we have found nothing that proves itself an ideal more than "chionanthus;" and we have an ethical preparation, which you all know, that has proven itself a perfect Godsend in this condition, and that product is "chionia." Before the hepatic cells become atrophic and hardened, there is a stage in which the liver becomes engorged, congested, hypertrophic; and in this condition we have hepatitis, an inflammation of the cells and connective tissue; and if this continues, then the liver breaks down, atrophies, and hardens. Now "chionia" does not act like any other laxative or hepatic stimulant; but instead of producing a severe catharsis, it works on the inflamed cellular tissue, bringing back the liver to its former physiological condition, allaying all inflammation, and gently stimulating the hepatic cells to perform their duty; and when we add nux vomica to this ideal hepatic stimulant, we have a tonic for the sluggish liver that cannot be equaled by any other remedy.—*Extract from a paper entitled "Indigestion, an Etiological Factor in Diabetes," read before the Medical Association of South Carolina by Dr. J. Will. McCanless.*

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## *Obituary.*

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GEORGE A. TRAYLOR, M.D.

We find the following brief notice in the *Journal of the American Medical Association* of March 19 ult.:

"George A. Traylor, M.D., University of Tennessee, Nashville, 1882, of Bryantsville, Ky., died suddenly from apoplexy while making a professional call in Lancaster, Ky.; aged seventy-one years."

Dr. Traylor was born in Adair County, Ky., his father being Milton Traylor, a farmer of that section, and his mother, Lavina (née Breeding), a native of the same locality. He entered the medical profession later in life than the average, having previously been successfully engaged in agricultural and commercial pursuits. However, he was a most earnest and persevering student, and throughout his professional career was also an earnest, sincere, and devoted student and practitioner. His integrity as a man made him a prominent and useful citizen in his entire walk in life. He was never married, but leaves two brothers, both residing in Adair County, with their families, and a number of relatives and friends there, who will mourn his loss. He commenced the practice of medicine at Hubble, Lincoln County, Ky., but some years ago moved to Bryantsville, leaving in both localities a large number of friends and admirers, who respected and esteemed him as a citizen, a true physician, and a friend.

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**PUTREFACTIVE PROCESSES.**—As an antiferment, to correct disorders of digestion, and to counteract the intestinal putrefactive processes in the summer diarrheas of children, Listerine possesses great advantage over other antiseptics, in that it may be administered freely, being non-toxic, non-irritant, and non-escharotic. Furthermore, its general compatibility with syrups, elixirs, and other standard remedies of the *Materia Medica*, renders it an acceptable and efficient agent in the treatment of diseases produced by the fermentation of food, the decomposition of organic matter, the endo-development of fetid gases, and the presence or attack of low forms of microzoic life.

An interesting pamphlet relating to the treatment of diseases of this character may be had upon application to the manufacturers of Listerine, Lambert Pharmacal Co., Saint Louis.

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SCOTT'S EMULSION is an ideal ready-made food for delicate children and thin, weak people. It provides nourishment when ordinary food doesn't.

**SUPRARENALIN IN PULMONARY HEMOPTYSIS.**—The note by Dr. A. C. Bird on this subject is particularly interesting to me, as I have quite recently had a parallel case to his.

My patient, a young clergyman, was sent to this district about two years ago, suffering from pulmonary phthisis. In September of last year he had a rather severe attack of hemoptysis, which, however, rapidly subsided under the ordinary treatment—absolute rest in bed, application of ice, etc. On December 6 he had a second attack—a very severe one; and in spite of the ergot and opium (both internally and hypodermically), sulphuric acid, hazeline, terebene, ice locally and in the mouth, and absolute rest of body and voice, the copious coughing up of blood continued until the patient's pulse began to show signs of collapse.

On December 19 I prescribed a teaspoonful of 1 in 5,000 solution of Suprarenalin (Armour) three times daily; and from the giving of the first dose the condition of the expectoration changed, the bright red gave place to the "foxy" color; and after the third dose of Suprarenalin, all trace of blood in the sputum had gone, and has not reappeared as yet.

I have still more recently used Suprarenalin in a second case of hemoptysis, with equally rapid results; and also in a case of fairly severe post-partum hemorrhage again, so far as one can tell, with excellent effect.—*Arthur S. Hadley, M.B.*

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**PEPSIN** is undoubtedly one of the most valuable digestive agents of our Materia Medica, provided a good article is used. **ROBINSON'S LIME JUICE AND PEPSIN** (see advertisement) we can recommend as possessing merit of high order.

The fact that the manufacturers of this palatable preparation use the purest and best Pepsin, and that every lot made by them is carefully tested before offering for sale, is a guarantee to the physician that he will certainly obtain the good results he expects from Pepsin.

---

**TROPHONINE.**—This is a tonic food, especially adapted to this season of the year.

Not a beef tea without nourishment, but contains the true beef juice, together with the nucleo-albumens.

Not a predigested food, but aids digestion when the enzymes enter the stomach.

Not a sugared water, but a food that adds the fat necessary for your patient.

Not a brewer's malt, but the true gluten of wheat. The peptones are perfectly balanced by the carbohydrates in the gluten; consequently the tissue-building products are not given off as nitrogen in the excreta. This is very important during convalescence.

# Listerine

**Non-toxic, Non-irritant, Non-Escharotic Antiseptic.**

**Absolutely Safe, Agreeable and Convenient.**

Listerine is a well-proven antiseptic agent—an antizymotic—especially useful in the management of catarrhal conditions of the mucous membrane, adapted to internal use, and to make and maintain surgically clean—aseptic—all parts of the human body, whether by spray, injection, irrigation, atomization, inhalation, or simple local application.

Listerine is a swift and sure destroyer of infusorial life; it prevents the various fermentations, preserves animal tissues and inhibits the activity, growth and motion of low forms of vegetable life: hence Listerine may be relied upon to destroy the activity of the living particles which constitute contagion whenever brought into intimate contact therewith.

**For diseases of the uric acid diathesis:**

## Lambert's Lithiated Hydrangea

A remedy of acknowledged value in the treatment of all diseases of the urinary system and of especial utility in the train of evil effects arising from a uric acid diathesis.

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Descriptive literature may be had upon application to the Manufacturers—

**LAMBERT PHARMACAL CO.,**

**St. Louis, U. S. A.**

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Be assured of genuine Listerine by purchasing an original package.



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increasing popularity. It thoroughly covers  
the field.**

**R. L. POLK & CO., Publishers.  
DETROIT, MICHIGAN**

**SUBSCRIBE NOW.**

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CONSTIPATION, always a lurking danger, is all the more prominent at this season of the year, when the more or less confinement of the winter months has added to the sluggishness of the bowels.

To constipation, with the backing up of the ptomaines and toxins in the system, may be traced various symptoms, on account of which the laity at this time popularly suppose that they need a spring tonic. What they really need in most cases is the proper cleansing of the intestinal tract. Many drugs or combinations of drugs have been used to give the laxative or cathartic effect, but all are more or less harmful in cases of habitual constipation.

In Pancrobilin, which contains  $\frac{3}{4}$  grain of ox bile and  $\frac{3}{4}$  grain of enzymes of the pancreas, we have an ideal remedy in the shape of a pill for all cases of habitual constipation. Pancrobilin is so prepared that it is not affected by the digestion of the stomach, and acts only in the intestines, where it not only aids in the digestion of the food, but stimulates the villi to absorption, and also stimulates peristalsis.

Habitual constipation in children can be overcome by taking 5 or 10 drops of the Liquid Pancrobilin once or twice a day.

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"THE HOME MODIFICATION OF COW'S MILK."—This is the title of a very excellent little brochure, handsomely printed, that will be sent to any physician on request by The Mellin's Food Co., of 291 Atlantic avenue, Boston, Mass. It is well worth sending for. In it the various details of scientifically preparing cow's milk for an infant's digestion are discussed and many formulas given. It is printed in two colors on fine paper, is fully and beautifully illustrated, and bound in full cloth. It will make a useful and valuable addition to your library.

We desire to say in this connection that Mellin's Food is one of the best and most reliable we have ever used. It is not only adaptable to infants, but as a certain nourishment in all cases of convalescence and during the acute stages of disease it is most invaluable. As a nutrient enema in a recent case of most distressing pernicious vomiting in pregnancy it has been most valuable.

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# One Hundred for \$1.00

## Have you tried NAPHEY'S WAFERS?

They are unsurpassed as a positive and speedy cure for Diseases of Women. They have been successfully prescribed by Physicians for ten years. We have increased the size of boxes from 25 to 100, which we are selling at the same price, \$1.00 per box, which puts them in the reach of every Physician for office use. Send for samples and literature.

NAPHEY & CO.

Warren, Pa.

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CINCINNATI SANITARIUM.—We have received the Thirtieth Annual Report of this most excellent institution for the treatment of Nervous and Mental Diseases. Since the death of Dr. Orpheus Everts, who did so much to add to the fame and justly-earned reputation of the Cincinnati Sanitarium, Dr. F. W. Langdon has been secured as Medical Director; and Dr. Williams, the courteous and efficient associate of Dr. Everts for so many years, is retained as Resident Physician, and will be assisted by J. A. Caldwell, M.D. Patients entrusted to these gentlemen will receive the same intelligent and skillful supervision and treatment that has been so marked a feature in the past. In keeping with its most successful past, the Report shows seventy-two recoveries to one hundred and fifty-five admissions, more than forty-six per cent; while the leading institutions of the world show less than thirty recoveries per one hundred admissions. Its naturally beautiful location in the suburbs of Cincinnati, with its grand park of twenty acres richly studded with grand monarchs of the forest; commodious and in every way suitable buildings, admitting of a thorough classification of patients; and all the latest and most improved appliances, are some of the superiorities it can claim.

Accompanying the Report is an abstract of the very excellent address of Dr. Langdon, as Chairman of the Section on Nervous and Mental Diseases of the American Medical Association, on "Neurologic Progress and Prospect," delivered at its last meeting, in New Orleans, in May last. Any one desiring copies of these very interesting pamphlets can receive them by writing to the President and General Manager, Mr. John C. Sheets, Station K, College Hill, Cincinnati, O.

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MUSCULAR SORENESS AND RHEUMATISM DUE TO GRIP.—In speaking of the treatment of articular rheumatism, Hobart A. Hare, M.D., Professor of Therapeutics in the Jefferson Medical College and Editor of *The Therapeutic Gazette*, says: "Any substance possessing strong antipyretic power must be of value under such circumstances." He further notes that the analgesic power of the coal-tar products "must exert a powerful influence for good." The lowering of the fever, no doubt, quiets the system and removes the delirium which accompanies the hyperpyrexia, while freedom from pain saves an immense amount of wear and places the patient in a better condition for recovery. The researches of Guttman show conclusively that these products possess a direct anti-rheumatic influence; and, among those remedies, antikanina stands preëminent as an analgesic and antipyretic. Hare, in the last edition of his *Practical Therapeutics*, says: "Salol renders the intestinal canal antiseptic." This is much needed in the treatment of rheumatism. In short, the value of salol in rheumatic conditions is so well understood and appreciated that further comment is unneces-

# Bronchiline

INDICATED IN

**Bronchitis, Coughs, Laryngitis, Pneumonia, Asthma**

A valuable remedy in the treatment of all irritable conditions of the respiratory tract. Efficient and agreeable. Contains no Morphine, Heroin, nor any form of opiates ; gives prompt relief. Has been endorsed by leading physicians all over the United States for fifteen years, Formula furnished upon application. Prepared in 16-oz. bottle. Prescription price \$1.00. A full-sized bottle sent to any physician, prepaid, upon receipt of 50 cents in stamps, to cover expressage.

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**Antidipsole** An Ethical Remedy  
for the Treatment of **Whiskey Habit**

Heartily endorsed by the leading physicians of this city. The countless testimonials we receive from physicians all over the United States enable us to assure you that ANTIDIPSOLE will give satisfaction in cases of chronic alcoholism. Write for booklet containing formula and testimonials from leading physicians.

If your druggist cannot supply you, we will send the medicine to your address, express charges prepaid, on receipt of \$2.00.

**NEAT-RICHARDSON DRUG CO. LOUISVILLE,  
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**To ST. LOUIS**

VIA MARTIN

**"WORLD'S FAIR ROUTE"**

N.C.&St.L.Ry.-Ill.Cont.R.R.

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sary. The statements of Professors Hare and Guttman are so well known and to the point and have been verified so often that we are not surprised that the wide-awake manufacturers placed Antikamnia and Salol Tablets on the market. Each of these tablets contains  $2\frac{1}{2}$  grains of antikamnia and  $2\frac{1}{2}$  grains of salol. The proper proportion of the ingredients is evidenced by the popularity of the tablets in all rheumatic conditions, and particularly in that condition of muscular soreness which accompanies and follows the grip. The Antikamnia Chemical Co., Saint Louis, will send samples to physicians on application. Please mention this journal.

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FIRWEIN (TILDEN'S) IN TUBERCULOSIS.—Much has been written in late years about sanitarium and climatic treatment for consumption, and there can be no doubt of the efficacy of such treatment. Unfortunately, the prevalence of tuberculosis is so widespread among the masses, who are almost entirely dependent upon their own work or upon the meager income of the family for sustenance, that unless the State steps in and provides free sanatoria in suitable locations it is useless to suggest this treatment for such sufferers. The toilers in our large cities affected with consumption cannot always leave their homes and shops to take up an outdoor life and unfamiliar outdoor work, much of which would be beyond their strength to perform.

While it is important to impress upon these sufferers the importance of fresh air, by day and by night, and to encourage hygienic reforms which will tend to increase the resistance of the system against the ravages of the disease and to prevent its spread to the healthy, it should not be forgotten that Tilden's Firwein is one of the most potent remedies for all forms of tuberculosis. The suggestion of Cavazzoni that iodine in tuberculosis acts not merely as a pulmonary antiseptic, but probably exerts an antitoxic action similar to that which, according to Brunozzi and Luccesini, it exerts in typhoid fever, goes a long way to explain the demonstrated efficacy of Firwein as a remedy for consumption. Besides iodine, Firwein (Tilden's) contains bromine and phosphorus held in solution by an elegant wine of fir, a product of the laboratories of The Tilden Co.



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The following outline of treatment is recommended by Nord. Med. in the medicinal treatment of glandular tuberculosis:

R. Iodi.....gr. i  
Ext. rhatany.....gr. iv  
Syr. simplicis.....oz. iiss

M. Sig.: One teaspoonful morning and evening.

And the following is recommended to be placed in the bath:

R. Iodi.....dr. iiss  
Pot. iodidi.....dr. v  
Aquae.....oz. viii

M. Sig.: To be put into the bath.

### VAGINITIS.

The following treatment is recommended by N. Y. and Phil. Med. Jour. in the treatment of vaginitis:

R. Salol.....gr. xlv-dr. ii  
Glycerini.....oz. viii

M. Sig.: To be applied locally on a tampon every second day; or:

R. Acetanilidi.....gr. xv  
Acidi tannici.....gr. viiss  
Ext. hydrastis canad.....gr. iv  
Sacch. lactis.....dr. iiss  
Ol. theobrom. q. s.

M. Ft. suppos. No. i. Sig.: One to be inserted every other day.

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EDITOR AND PROPRIETOR

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### *Original Communications.*

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**"THE SCIENCE OF MEDICINE—THE SCIENCE OF HUMANITY."**

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BY L. A. MCSWAIN, M.D., PRESIDENT, OF PARIS, TENN.

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In the year 1830, in the month of May, the leading Physicians of this State met in the city of Nashville and organized the "Medical Society of the State of Tennessee," and wrote upon their escutcheon, "The Science of Medicine an important department in the Science of Humanity." After the lapse of 72 years, at the reorganization in Memphis, and the adoption of the new constitution, the name was changed to that of "Tennessee State Medical Association," but the motto remained unchanged. It is well. Truth changes not. Time and progress

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\* Annual Address delivered before the State Medical Association at its Seventy-first Annual Meeting, held in Chattanooga, Tenn., April 12th, 1904.

have wrought changes innumerable within the last three quarters of a century, which correspond with the life of this Association, but have only added emphasis to the truth contained in this motto.

The thought occurred to me to say something on this occasion in regard to the relationship of the Science of Medicine to the Science of Humanity; hence the adoption of this motto in slightly abridged form, as the title of this Address.

Science, in its most primitive sense, is to know. To *know* Medicine, involves the *Science of Humanity*. To know Humanity, is therefore fundamental to Medical Science, without which, Medicine at once ceases to be a Science, and as it has been observed in all history, is a heterogeneous mixture of Witch-craft, Superstition, Charlatanism, Empiricism, Fanaticism, and Deception.

In direct ratio, as the knowledge of individual and collective Humanity increases, does Medicine become more and more a Science.

Humanity implies a physical, mental, and moral being; "a material Body, an immaterial Mind, and an immortal Soul." These three elements, although distinct, are strangely blended to make man. So intimate is their connection, so intricate the process by which they are interwoven, that no proper conception can be had of mankind by the study of one of these elements to the exclusion of the others. We must comprehend the fact that all impressions and influences, made either from within or without the man, involve his three-fold character.

Errors are not uncommon in this regard in the application of the Science, or, if you please, the Art, or Practice of Medicine. To regard man only from a physical standpoint, leads to errors, both in regard to the causes and the cure of his diseases. To regard him as mind only, and conclude that all his ailments are mental or imaginary, leads to the most erratic conclusions, and to the inexcusable and criminal neglect of material agencies, whereby the loss of life may result; instances of which are not uncommon, even in this enlightened age, and under our own observation, in the practice of so called Christian Scientists and other quasi religious orders.

To dwell only on that which is immortal, to regard the Soul only, to look upon all diseases as the result of immorality and sin, leads to the most fanatical practices fraught with great evils to both Body and Mind, and may result in the overthrow of the Soul itself.

In the application then of the Science of Medicine, due regard must be paid the body as a great complex mechanism, a co-ordination of the physical forces which is so essential to the welfare of the whole. We must consider that the mind wields a large influence over the body both in health and in disease, and our Therapeutics must include agencies whose effects are mental in their application, as well as those which are physical..

To "administer to a mind diseased," to bind up the wounds which sorrow has made, to sympathize with distress, to inspire hope and strengthen confidence, are among the most difficult problems of Medical men, a proper solution of which may bring health and healing to the body. Not the least of these three factors, is the soul of man. That which is neither physical or mental, but a distinct entity, breathed into man by the Infinite, and creating him a moral being. The causation of some of the most unmanageable diseases both of body and mind, is traceable to immorality. The cure of which is improbable, if not impossible, unless the moral perversion can be overcome. We conclude then, that only by the dilligent study of individual man, physical, mental and moral, can we have the knowledge or Science of Humanity that is so essential to the application of the Science or knowledge of Medicine. All rational Therapeutics have their basis upon these principles, all else is Empiricism.

What think you then of a Doctor, (so called), who presumes to administer remedies to those who fall by the wayside in the struggle of life, who knows but little of the body, but less of the mind, and who cares nothing for the Soul? What would you think of a man who knows absolutely nothing of a locomotive, mounting the cab of an engine to which is attached a train of cars, laden with Human Freight, and with a reckless daring born of ignorance, opens wide the throttle, and perchance, hurls the unsuspecting passengers to inevitable ruin? Before a man may run an engine, he must study long days and weeks and months

under a master. He begins by wiping off the engine, studies each piece of the ponderous machine, becomes familiar with every wheel, piston, cog, and valve. He must understand the gauges, the brakes, the signals, the power of the mighty iron horse, indeed everything connected with the mechanism of locomotion, and even then he is not competent until he has taken his stand by the engineer, and gone over the road again and again, observed every switch, bridge, and landmark along the way—and even then he assumes the position of engineer with fear and trembling at the mighty responsibility. This law of qualification applies to every avocation and is pre-requisite to every business or undertaking in the affairs of men.

So should it be with the Doctor or with anyone who essays to administer remedies to the diseases of tri-partite man. He begins, perchance, sweeping the office, and arranging the books and instruments of his preceptor. He spends weary months and years acquiring a knowledge of the structure of the body. With Scalpel and Forceps in the weird light of the dead room, he dissects the brain, the heart, the lungs, indeed all the organs of the body; observes their size, their structure, their position and relationship to other organs, their blood and nerve supply; then traces the source and distribution of every artery, vein, and nerve, studies the bony framework of the body, its muscles, joints, and ligaments, and then, with microscope in hand, looks down into the ultimate cells, scrutinizes the constituents of the blood, the very source of life, compares healthy with diseased structure, and learns to distinguish the normal from the abnormal.

But his work is just begun. Turning to his Physiology, he must know the offices performed by the various organs, the character of the secretions and excretions, the processes of waste and repair, the functions of digestion, and assimilation, of respiration and circulation. Then through the biological laboratory does he study the germs of disease and behold their work of propagation and the manner of their subtle invasion and destruction of the tissues and organs of the body, in their hidden fastness. He must also know material medicine, the character and properties of drugs, their action upon the human economy, their incompatibilities, their poisonous effects and antidotes. If a surgeon, he

must in addition to all this, understand the technique, the instruments required, and the elaborate principles of asepsis and antiseptis involved in an operation. Then again the student must acquaint himself with the more delicate subjects of conception, the growth and development of the foetus in utero, the process of parturition, the advent of the new-born child, its needs together with those of the mother at that critical and trying ordeal.

He must take his stand at the bedside of the sick and injured, and study disease in its different stages and manifestations, the indications for treatment, the dangers immediate and remote, the diseases peculiar to infancy, middle life, and old age, the natural changes that occur in the body during the periods of growth and decline. He must consider also the mental and moral traits of the patient, his environments, his habits, his hereditary predispositions and tendencies to particular diseases. He must also cultivate in the sick room a professional mannerism, exhibit a confidence in his own ability and resources by which he inspires confidence in the patient and attendants.

Notwithstanding the chief mission of the physician, is if possible, to cure disease, he will often be brought face to face with conditions that defy his best directed efforts and are hopelessly incurable. But even after all his resources have been exhausted, the true physician does not forsake his patient. But, when in the shadow of an overwhelming fate, he recognizes the approach of the relentless messenger as he comes to summon the soul to its final account, he should soothe the pain and anguish of dissolution, and point the weary sufferer through the darksome portals that mark the end of this mortal span, but which open the entrance to the land Elysian.

After all this preparation, and much more, not laid down in books, or "nominated in the bond," a man with a conscience, enters upon the duties of a doctor of medicine, with a sense of obligation and responsibility well nigh paralyzing.

Contrast if you please, this student, well bred in the sciences of Humanity and Medicine, with the conscienceless quack, the presumptuous charlatan, or the greedy and avaricious manufacturer of secret and patent medicines, who are in the business of tampering with human lives, not for the study of the science of medicine,

as applied to human needs, but like the would-be statesman in defining his position, favored a "tariff for *revenue only*."

But you say: Why do people allow themselves to be imposed upon by the pretender in medicine, and why do they buy and use drugs of which they know nothing, and for the administration of which no one is responsible? There are several reasons. As far back as we have any account of the human race, there has existed in the mind a disposition to fathom the mysterious, and to experiment with the unknown; it was this that led mother Eve "to partake of the fruit of that forbidden tree, whose mortal taste brought death into this world, and all our woe." Then again for thousands of years of the world's history, medicine as a science had no existence, the treatment of disease being a mixture of witch-craft, incantation, exorcism, deception, and cruel imprisonment or banishment. From that dark age of mythology and superstition, the human mind has emerged very slowly. Errors find easy lodgment in the mind which require great effort and hundreds of years of time to eradicate, people preferring to hug the delusions of the fathers, rather than accept a scientific truth.

There is also a kind of credulity in the human mind easily played upon by the fair promises and assurances, the flaming advertisements and attractive chromos, which are a necessary adjunct to the success of the quack and patent medicine man. Again, there is a magic in printer's ink. People are prone to accept as facts what they see in print.

Contributory to this patent medicine phrenzy are the certificates of public men, even ministers of the gospel endorsing this stupendous folly. The apology we would offer for these, is that, however wise and good they may be on other lines, they know nothing in regard to medical science, and in any court of the country their testimony would be ruled out on the score of incompetency. There are also church papers, and even some medical journals that allow (for a consideration) space in their publications to advertise these frauds. Ministers of the gospel and church papers need be more cautious in their indorsements lest they become accessory to the formation of most pernicious drug habits.

There is just one other class of which we would speak, but with diffidence, for he is our brother, and for him, we entertain a good degree of regard and would not, wantonly, wound his sensibilities, but we have heard it said that some *real* doctors do now and then permit the use of, and have actually been known to prescribe a preparation, a medicine (so-called), a something, the ingredients of which were entirely unknown to them, and that there have appeared in certain quarters certificates from doctors endorsing such nostrums. Is it possible?

I know that my brother is sorely tempted, for the ubiquitous agent besieges his office day after day with an exhibition of his wares, extravagantly loads his table with samples, and is persistent in his praises of the virtues of the articles contained in the cartooned packages, ready made for all the ills to which human flesh is subject. But Brother, as in moral and spiritual matters, there is a way of escape from temptation by resisting the powers of darkness and ignorance. So in the practice of your art, you can escape the clutches of the commercial medicine man, by a confidence in, and fidelity to our noble science. Thereby you will contribute to the best interests of your clientele, maintain your self esteem, and advance the honor and dignity of your profession.

The medical profession condemns these patent nostrums and the methods of quacks, advertising specialists, and impostors, not because of their interference with the business or financial interest of the doctor, but for the same reason that we urge medical legislation for the protection of the health and lives of the people. Men of medical science know the pernicious effects of the narcotics and stimulants contained in many of these mercantile preparations and nostrums. The cunning manufacturer, well understands how to increase the sale of his wares by loading them with drugs that entail habits, and thereby his preparation creates its own demand. *He is in the business for money.*

On the other hand, every law on the statute books relative to the prevention of disease, the arrest of epidemics, quarantine regulations, the organization of State Boards of Health, the United States Marine Hospital Service, the institution of the various public health associations, prison reform, the erection and equipment of hospitals for the insane, blind and disabled, every sanitary



regulation, state, county, and municipal, have had their origin in the medical profession, and received the hearty support of medical men everywhere, *and that, "without the hope of fee or reward."* Yet humanity, bleeding from every pore, suffering from all sorts of imposition, from quacks, certain pseudo specialists, impostors, nostrum venders, faith cures, *et id omne genus*, repeats again and again, the cry that rang out in the original court of a Roman governor on a certain momentous occasion, "Give us Barabbas! Give us Barabbas!" The historian of those times incidentally mentions the fact that *this Barabbas was a robber.*

Again, the tendency to disregard the injunctions of medical advice, and to violate the most common principles of the laws of health, is a marked characteristic of humanity. Physicians and health officers have often been seriously handicapped, and blamed for inefficiency, when in reality, alleged failures were occasioned by indifference to their suggestions. In my own county, a few years ago, a case of small-pox was found in the practice of a competent physician, who immediately reported the case to the County Board of Health, and urged the necessity of isolation and quarantine of the patient, together with all who had been exposed to the contagion, and vaccination of the community in which the case occurred. After considerable trouble and delay, this was accomplished; but only a few days afterward the county judge, in the face of the protest of the health officers, dismissed the guards and turned the infected negroes loose on the town and country. The result of this blunder, was to precipitate an epidemic of small-pox, that cost the county some forty thousand dollars, to say nothing of the loss of life, and suffering from a loathsome disease. Another melancholy incident of the kind occurred in the neighborhood of this city, (Chattanooga) during the Spanish-American War, when the flower of American manhood encamped at Chickamauga, were stricken down with a preventable disease and died by the score, not on account of the inefficiency of the medical staff, but because of the total and offensive disregard of their advice, by an arbitrary commanding officer.

Not only is there this indifference in regard to medical science as it relates to humanity, but there exists a spirit, especially among some aspirants for political office, a kind of pandering to

the unlearned, a species of demagoguery, if you please, in order to secure or maintain official position. This class of men, as a rule, are opposed to all progress in matters of science; they draw the line at what they are pleased to call innovations, and claim to have great love for the *dear people*. You will find them opposed to medical practice laws, opposed to vaccination, opposed to sanitary regulations, not in sympathy with health boards or quarantine regulations, opposed to all sorts of prohibitory measures and reform movements. This character has been, in the past, quite an obstacle to progress, especially to medical progress, but his days are numbered. The people are becoming better informed on these lines and are beginning to suspect that it is not so much his love for them, but for his own advancement, that he has been led to sacrifice (?) himself on the public altar.

Greater advances in the interest of humanity will be made by medical science in the near future, in consequence of the better organization of the profession. The county, district, state, and national medical associations, being now placed upon a new basis, can exert a greater influence in regard to legislation, and upon all matters pertaining to the prevention of disease, the preservation of health, and the prolongation of human life.

Some of the advances contemplated are of such general interest that they can only be secured through National Legislation. Such as the "Pure Food Bill," which has recently passed the House of Representatives, and which we trust will become a law. Coupled with this should be established a department for the inspection and analysis of medical plants and pharmaceutical products, together with all secret nostrums, and patent and proprietary preparations. Manufacturers of these latter compounds should be compelled under the law to label in plain language their preparations, giving the name and amount of every ingredient contained in them. Heavy penalties should be fixed for the adulteration of drugs, or for misrepresentations in regard to the ingredients contained in a given compound. There should also be established some National system for the destruction of mosquitos, now known to be the instruments in the propagation of malaria and yellow fever; and of rats, the carriers of the infection of Bubonic Plague.

Another subject of National importance is the study of criminology. Whether criminals are born or made, is a question of vast proportions. It is most probable that crime, like certain diseases, is to a degree hereditary, that is, the children are born with a tendency, or predisposition towards the commission of crime, which tendency is most usually intensified by vicious environments.

It is estimated that in the United States there is spent annually on criminals eight hundred millions of dollars. Now if science, by the use of instruments of precision aided by an aggregation of statistics can demonstrate the mental characteristics, and the hereditary and other influences, that go to swell the great army of criminals, there should be measures provided by the government to diminish criminal classes, by correcting the vicious tendencies and environments, by which criminals are propagated. For this purpose, a bureau on criminal anthropology should be established and equipped by the National government.

Scientific investigation on this line, coupled with the knowledge we now have of heredity in the production of certain diseases, such as consumption, etc., would naturally lead to the consideration of marriage laws, prohibitory of matrimonial alliances of criminal and diseased classes. We do not at present argue in favor of or against such laws, but to be effectual they will of necessity have to be enacted by the National government. People are somewhat migratory in their habits, and should one State enact marriage laws, persons who wish to evade them could simply transfer their residence to another State, in which such restrictions did not exist.

There should also be established by the National government a bureau of information from which literature could be distributed, demonstrating the cause and effects relative to the subjects herein indicated, on which the people need enlightenment.

We have thus mentioned some of the advancements of a National character, but for the most part medical legislation, under existing constitutions, comes under the head of what is known as the Police regulations of the respective States, and hence are subjects of legislative enactment by the State.

There should be an effort upon the part of all the States to secure a uniformity of laws relative to medical practice and also a system of reciprocity, so that a legally qualified practitioner in one State could remove into another and continue practice on proper certified credentials, without being subjected to additional examination.

Science being the same everywhere, there is no reason why all sanitary regulations and laws relative to public health in the different States should not conform to a common standard.

In our own State the medical laws are reasonably good, but there are some changes that would be beneficial. The system of electing county health officers by the county courts is very unsatisfactory, and should be abolished upon the grounds that the courts are not competent to judge of the qualifications necessary for that position. The office of both county and city physician should be filled by appointment of the State Board of Health, upon the recommendation of the county medical societies. All appointments of public health officers should be made without regard to politics.

Section 3620 of the Code of Tennessee, makes it unlawful for any itinerant physician, or vender of any drug, nostrum, ointment, or application of any kind intended for the treatment of diseases, to sell or apply the same, or for such itinerant physician or vendor, by writing, printing, or other methods to profess to treat or cure diseases or deformity by any drug nostrum, manipulation, or other expedient, the only exception to this law being that it does not apply to druggist or merchant. This on its face appears to be a good law, and was doubtless intended to prohibit the things indicated, but the State revenue laws nullify this important enactment by granting a license to a company or to an individual to publicly sell drugs, ointments, nostrums, etc. The State license or privilege is fixed at one thousand dollars per annum for the whole State, and in addition a county and municipal license, ranging from fifteen to forty dollars, according to the population. The purpose of the law is clearly intended to be prohibitory; its violation a misdemeanor, and the penalty, a fine of from one hundred to four hundred dollars. But the State occupies the rather unique position of compromising itself, by the enactment of a

law positively forbidding a thing, and then *for a consideration*, sanctions the violation of the law. In all reason and conscience this section of the medical practice law should be stricken out entirely, or amended so as to prevent the State from issuing license to persons to violate the law, or such person should be a legally qualified practitioner of medicine, endorsed by the State Board of Medical Examiners, (a thing which is not probable).

There is also in our State, AN EXCEPTION of which we have a word to say. Under the medical practice law, a *man* is not allowed to write a prescription, pull a tooth, fill a prescription, or cut off a limb, until he shall have passed through the curriculum of a Medical, Dental, or Pharmacal College, or has stood an examination before a Board of Examiners, and all this is right. But I have in mind a dame of uncertain age, unkempt hair, bad teeth, foul breath, long finger nails, sore eyes, dirty hands, and faltering step, who never read a book on any branch of medicine, nor perhaps any other book; she is full of superstition born of ignorance; she does not believe in new-fangled ideas; she does not know the meaning of the word antiseptic, but claims to do her "doctorin" in the old way,—yet she is the *exception*, made such by the Legislature, and may take charge of that branch of medical practice, which every intelligent practitioner knows to be one where positive knowledge, and the most painstaking care are required, and which are so essential to the welfare of both mother and child. We certainly do not object to turning over this part of the practice to women, if they be required by the law to qualify themselves, but in the name of humanity, we protest against everyone being allowed to endanger the life of the mother and her innocent offspring, through ignorance that breeds carelessness and criminal neglect, and therefore would suggest the striking out of *the exception*.

But the time admonishes me that this paper, in length at least, is somewhat exhaustive. The rambling thoughts of this address have been gotten together in the brief intervals occurring during a busy season. Some of the ideas may seem to be crude or Utopian, perhaps may contain a suspicion of criticism of certain existing conditions, but I beg to plead "not guilty" of views inclined towards asceticism, or in any degree pessimistic, for I

am firmly possessed of the belief in scientific progress on all lines, especially in the allied sciences of Humanity and Medicine, and look forward to the good time coming when it shall not be said: "God and the doctor we adore, when sickness comes, not before. When we get well, both are alike requited. God is forgotten, and the doctor slighted," but a period in the near future shall mark the triumph of Science over darkness and superstition, and the doctor no longer be summoned, only in emergencies, to apply his art to the cure of maladies produced by a disregard of the laws of health, but he shall be an officer of state, clothed with honor and authority, and salaried by the government. His mission shall be as an Apostle of the Goddess Hygeia to teach the people the science of health, the art of keeping well. Under his genial administration, crime and disease shall be the exception, peace and health the rule. Healthy parents shall behold with pride the rosy cheeks of their children, which, like olive plants, shall grow up and become fruitful. National prosperity and happiness shall be the result of a symmetrical manhood and womanhood, endowed with physical strength and beauty, mental excellence, and moral rectitude. Mankind shall not be hurriedly summoned from the stage of the world's drama in the innocence of childhood, the bloom of youth, or the busy activities of middle life, but, in a good old age, at the night-fall of life, willingly yield to the influences of a gentle and peaceful euthanasia.

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### TENNESSEE STATE MEDICAL ASSOCIATION.

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Abstract of the Seventy-first Annual Session, held in Chattanooga, Tenn., April 12, 13 and 14, 1904. Prepared by Wm. Whitford, of Chicago, Ill., official stenographer.

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The Association met at the Read House under the Presidency of Dr. I. A. McSwain, of Paris, over two hundred members being present, it being the largest meeting ever held.

Addresses of Welcome were delivered by Hon. A. W. Chambliss, Mayor of Chattanooga, and Dr. J. R. Rathmell.

The response to these addresses was made by Dr. Frank Wilson, of Pulaski, in lieu of Dr. C. A. Abernathy who was unable to be present.

## ORGANIZATION.

Dr. J. N. McCormack, of Bowling Green, Ky., delivered an admirable address on this subject. His remarks created a favorable impression. He furnished the Secretaries of the County Medical Societies some valuable pointers relative to this work.

The House of Delegates transacted the business brought before it expeditiously. It met promptly one hour in advance of the scientific sessions, thus enabling the members of the House to hear all of the papers that were read and to take part in the discussions. We would suggest that other State Societies emulate Tennessee in the matter of transacting their business so as not to interfere with the scientific work. The action of the House of Delegates, we hope to be able to give in full in our next number.

## MEMBRANOUS CROUP.

Dr. J. T. Herron, of Jackson, reported nine cases of this disease. The author had used antitoxin in these cases with very beneficial results. He recommended giving antitoxin early and in large doses. The physician was expected to do three things, if necessary, in every case of membranous croup. First, give antitoxin; second, intubate, and, third, resort to tracheotomy. He believed that if antitoxin was given early and in large doses, there would be very little need either for intubation or tracheotomy.

## DIPHTHERIA.

Dr. J. B. Witherington, of Munford, gave a resume of cases treated with antitoxin. During an epidemic that occurred in his practice during 1900, he treated 38 cases with antitoxin, and his partner, Dr. O. M. Walker, and himself had treated since that time 24 cases. He emphasized the statement that in all his professional career he had never used any remedy for any disease that gave him such uniformly satisfactory results as antitoxin in the early stages of diphtheria. The 62 cases treated occurred in 9 families. The clinical diagnosis was confirmed in 9 families by the microscope. In these 9 families there were 21 cases of the disease. He had treated 7 laryngeal cases, all of which recovered. In 3 of these the microscope confirmed the clinical diagnosis.



The discussion on these two papers was participated in by Drs. Frank Trester Smith, J. A. Crook, Wm. S. Scott, C. P. Fox, J. S. Nowlin, Louis Le Roy, all of whom concurred in the main with the essayists; and spoke of having obtained gratifying results from the use of antitoxin.

#### LA GRIPPE AND ITS COMPLICATIONS.

Dr. A. J. Swaney, of Gallatin, who was prevented from being present by illness, contributed a paper on this subject, in which he said treatment must be based upon common sense principles, and the physician must rely on his own discretion in the management of his cases.

#### CHRONIC DYSENTERY — A PROTEST.

This was the title of a paper read by Dr. A. B. Cooke, of Nashville. He reported two recent cases, which were fair illustrations of abuse of the term chronic dysentery, and the object of the paper was to present his personal views as to the real nature of so-called chronic dysentery, and to beg that the term be dropped from the medical vocabulary. He emphasized the following points. (1) That almost without exception the condition so-named is purely local; (2) that the term chronic dysentery, as ordinarily employed, does not and can not refer to a definite pathologic entity, but rather covers a wide variety of local diseases in no way related to dysentery. (3) That a chronic discharge from the bowels, unattended by the well recognized symptoms of a general systemic disease process, always indicates a lesion of the rectum, sigmoid, or colon. (4) That the idea of a necessary relation between bloody discharges and chronic dysentery is based upon a false assumption and should be both abandoned and forgotten.

#### SYMPOSIUM ON PNEUMONIA.

Dr. Louis Le Roy, of Nashville, discussed the bacteriology and pathology of this disease; Dr. John A. Witherspoon, of Nashville, the early diagnosis and semiology; Dr. E. G. Wood, of Nashville, medicinal treatment; Dr. Thomas L. Maddin, of Nashville, general considerations; Dr. J. S. Cain, of Nashville, history and value of blood-letting in the treatment of the disease; Dr.

E. A. Cobleigh, of Chattanooga, the local treatment, and Dr. C. P. Mc Nabb, of Knoxville, some causes of error in the diagnosis of pulmonary affections, and their explanation. This was one of the most attractive features of the meeting.

#### ABSCESS OF THE BRAIN.

Dr. W. A. Bryan, of Nashville, read a paper on this subject, in which he reported an interesting case, and emphasized the following statements: (1) Cerebral abscess is to be considered chronic after it has been present six weeks. It requires that time for the formation of the so-called pyogenic membrane, which is nothing more than a fibrous limiting wall. (2) A chronic brain abscess may last indefinitely. Cases are reported varying in duration from a few weeks to as much as twenty years. (3) Chronic abscess of the brain may remain confined within the limiting wall indefinitely, causing few or no symptoms, and by extension through the fibrous wall involve the meninges or rupture into a ventricle, producing marked secondary symptoms and early death. (4) Brain abscess frequently follows an otitis media, without evidence of mastoid disease, and might do so, as in his case, even when the cells are completely necrotic. (5) It may result from otitis by direct extension, by large necrotic involvement of the bone, or by thrombo phlebitis. (6) Pus from brain abscess is thin, viscid, like synovial fluid, and acid. (7) The most important symptoms, aside from peripheral disturbances, are pain, mental hebetude, subnormal temperature, slow pulse, and vomiting. (8) Increase in temperature above normal signifies either a new involvement of brain tissue, or inflammation of the meninges. The latter is usually accompanied by chill. (9) Congestion of the veins of the fundus may be greater on the sound than it is on the diseased side.

#### HOLOCAIN.

Dr. Frank Trester Smith, of Chattanooga, in a paper on this local anesthetic, emphasized its advantages thus: (1) It is a reliable anesthetic. (2) It is more efficient on inflamed surfaces. (3) Solutions may be sterilized by boiling without affecting the drug. (4) It has antiseptic properties. (5) It produces no

abrasion of the corneal epithelium, and does not interfere with healing of the mucous membrane. (6) It has no effect on the circulation, neither causing anemia, as does cocaine, nor hyperemia, as does eucaine. (7) It does not effect the pupil, the accommodation, nor the tension of the eye. On these accounts he believes it to be the best local anesthetic for general use, and that it should supercede cocaine almost entirely.

#### CONSERVATIVE SURGERY OF THE HAND.

Dr. Paul F. Eve, of Nashville, cited cases which illustrated in a striking manner what can be accomplished by conservative surgery of the hand. In the treatment of the various wounds of the hand, he said every attention should be paid to thorough cleansing and drainage, and no wound should be thought too trivial to receive proper attention. Many a hand has been rendered partially or wholly useless by the improper treatment of injuries of it. He made a forcible plea for the preservation of the hand, and urged that physicians be careful in the treatment of this wonderful piece of mechanism.

#### PRESENT STATUS OF THE ETIOLOGY OF MALIGNANT GROWTHS.

Dr. Raymond Wallace, of Chattanooga, read this paper, and stated that inasmuch as the dividing line between various neoplasms is so difficult to determine, and the transition from a non-malignant to a malignant growth depends upon such apparently slight causes; that contrary to all infectious conditions which might be considered analogous, there has never been recorded a case of malignancy in the new-born, and exceedingly few cases in childhood, which also militates against any theory of direct heredity; a multiplex and varying etiology seems the most plausible. Intrinsic irritation of the cell proliferating mechanism in the nucleus, may with the advance of cell chemistry yield certain autogenous factors, but as extrinsic factors may be summarized, various physical, chemical, or physiological irritations and irritations caused by parasitic life, any of which cause an evident disturbance in cell proliferation, which leads to insane proliferation and the consequent formation of neoplastic growths. The

degree of malignancy depends upon the rate and type of proliferation, and the loss of function and consequent reversion in type of proliferating cells attest the theory of nuclear or chromatin alteration or rearrangement.

#### VISUAL INSPECTION OF RAILWAY EMPLOYEE:

Dr. C. M. Capps, of Knoxville, hoped that at no distant date, railway companies will more fully realize the importance of having a competent inspector for each railroad division, as a means of more economic management.

#### LEUCOCYTES IN TYPHOID FEVER.

Dr. Wm. Litterer, of Nashville, emphasized the following points: (1) The total and defferential count is of the greatest assistance in diagnosing typhoid fever from the various inflammatory processes and most of the specific infectious diseases, which is simply made by exclusion. (2) Most valuable aid in detecting complications and also in making a good, bad, or indifferent prognosis. (3) In the majority of cases of typhoid fever in the first week there is a characteristic morphological count. (4) He fully agrees with H. Higley, of New York, when he says that the definite value of the differential leucocyte count in the early diagnosis of typhoid fever is yet problematical; but it seems certain that when used in addition to the total leucocyte count, more information can be obtained than by employing the total count alone.

#### THE TREATMENT OF PUERPERAL INFECTION.

Dr. J. T. Altman, of Nashville, urged the importance of more careful prophylaxis, and impressed the latest and best methods of prevention and cure of cases of puerperal infection. Since the advent of bacteriology, the true cause and pathology of puerperal infection has been settled, and entirely new ideas of treatment advanced, which, he thought, was a decided step forward in the managment of the severer types of this disastrous condition. Hysterectomy for puerperal infection has saved a few cases, but he regarded it as a very doubtful procedure. The removal of infected veins had few advocates, and little to recommend it.

## VENEREAL DISEASES AND THE SOCIAL ORDER.

Dr. O. J. Porter, of Columbia, discussed this subject at great length, and concluded that earlier marriages would prove a telling factor among the agencies which tend to lessen the prevalence of venereal diseases.

## AFTER-TREATMENT OF ABDOMINAL SECTION.

Dr. L. E. Burch, of Nashville, emphasized the avoidance of opium and the early movement of the bowels in desperate cases in the after-treatment of abdominal sections; also the absence of all relatives and friends from the sick-room, until the crisis has passed; the administration of water in almost satisfying quantities from the first; the early propping up in bed, especially in old people; the avoidance of milk as a diet until the sixth day, and last, but not least, the use of a saline enema at the completion of every abdominal operation, for the relief of thirst.

## INTERNAL ANTISEPTICS IN TYPHOID FEVER.

Dr. J. A. Crook, of Jackson, advocated the principle of drainage and antiseptics as the important features in the treatment of typhoid fever, and reported his successful experience in the use of carbonate of guaiacol combined with thymol, menthol, and eucalypol, as internal antiseptics in this malady. While many of the prominent members of the profession had denied the possibility of intestinal antiseptics with any drug or combination of drugs, yet the clinical experience of hundreds who had used intestinal antiseptics proved that the bowel may be rendered practically sterile. Some of these clinical reports the author quoted. In most instances the diagnosis was established by the Widal test and diazo-reaction. Acetozone was mentioned as a valuable remedy in this disease, and testimony given in favor of its use.

## SANITARY ADVANCES.

Dr. E. H. Jones, of Murfreesboro, said that American sanitary measures and precautions made it possible to inhabit the jungles of our new island possessions, without which the death-dealing enemies to the human organism would devastate our armies, pro-

tors and speculators. He believes that the much contended army canteen does not add to, but rather depreciates the resisting forces in combatting the prevailing maladies incident to tropical climes.

#### TETANUS.

Dr. T. J. Happel, of Trenton, referred to the exhaustive review this subject, which was published in the Journal, Aug. 29, 1903, after which he reported three cases in which he obtained good results from the use of the calabar bean in the treatment of them. These cases were detailed. He said the calabar bean is most highly commended by Shoemaker as a curative agent of great value in the treatment of tetanus, he holding that under its use full doses, pressed to its physiological effects, fully one-half the cases recover.

Dr. W. D. Haggard, of Nashville, reported a case of gall-stone in the common duct, one of cyst in the kidneys, a case of cancer of the umbilicus, a fibromyoma of the uterus, and tubercular osteitis of the femur, and exhibited specimens.

Papers were also read by Dr. W. P. King, of Lutts, on "The Microscope in Diagnosis," "Inflammation and Ulceration of Sigmoid Flexure," by Dr. F. B. Reagor, of Shelbyville; "Duties of the Profession Concerning Fanaticism, Frauds, Fools, and Fads," by Y. L. Abernathy, of Chattanooga; "The General Practitioner's Relation to Insanity and its Management," by Dr. M. Campbell, of Knoxville; "Hysteria," by Dr. J. W. McQuillan, of Chattanooga; "Therapy of Sodium Chloride," by Dr. J. S. Nowlin, of Shelbyville.

#### OFFICERS.

The following officers were elected for the ensuing year: President, Dr. Paul F. Eve, of Nashville; First Vice-President, Dr. E. H. Jones, of Murfreesboro; Second Vice-President, Dr. G. D. Bicknell, of Madisonville; Third Vice-President, Dr. C. E. Wyree, of Trenton; Secretary, Dr. Deering J. Roberts, of Nashville; Treasurer, Dr. W. C. Bilbro, of Murfreesboro.

Delegates to the American Medical Association, elected for two years: Dr. J. T. Herron, of Jackson; Alternate: Dr. J. B.

Witherington, of Munford; Alternate for one year in place of Dr. W. J. Miller, who is quite ill and will not be able to attend, Dr. Cooper Holtzclaw, of Chattanooga.

The Secretary reported that over 1000 members had paid their dues through Secretaries of County Societies, and that he had assurances that quite a number of others would send in their dues in time to be incorporated in the Transactions for 1904. Take it all in all, it was the most successful and satisfactory meeting ever held by this organization. Some minor but essential modifications to the By-laws were adopted, which will appear in our Report of the work of the House of Delegates, which we hope to be able to place before our readers in our next issue.

The Association adjourned to meet in Nashville, the second Tuesday in April, 1905.

## --- **AURAL CONGESTION WITH THREATENED ABSCESS.** ---

BY C. L. STRENSSEN, A. M., M. D.,

Professor of Materia Medica, New York. Author of "Naso-Pharyngeal Disorders," Etc., Etc.

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I would like to mention to my confreres that, in the treatment of acute attacks of aural congestion, with every indication of suppuration, both internal and external, and seriously jeopardizing the tympanum, and not infrequently with evidences of threatening abscess accompanied with the most lancinating pains, I have prescribed Antikamnia & Salol Tablets with most satisfactory results. The congestion, fever and pain promptly yield to the persistent use of these tablets, and to attain this I ordered two tablets to be given every two hours. I am firmly convinced that with careful ablution and syringing of the external aural cavity with a mild antiseptic and anodyne solution, and the administration of this remedy, I have aborted the threatened attack and thereby undoubtedly saved the patient from a suppurative sequela, and no doubt in many instances, from operative interference, necessitating the trephining of the sphenoid, or the opening of the antrum to save life. As every practitioner knows, the operation is not infrequently fatal, if the case be an advanced one and the patient an aged one.



As to the local application, I simply resort to tepid water, to which may be added a mild antiseptic, say five grains boric acid to each ounce, and a little tincture opium. This makes an admirable application. This solution carefully injected from two to four times daily to warm and cleanse the vestibule of the ear, and with the administration of Antikamnia & Salol Tablets, or Antikamnia & Codeine Tablets, the practitioner will be rewarded with most gratifying results.

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## *Abstracts.*

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### ON UROTROPIN.\*

BY DR. HENRI VINDEVOGEL,

Laureate of the University of Brussels, 1897-1899.

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Dr. Vindevogel aimed at determining whether and in what manner Urotropin is decomposed in the organism into ammonium and formalin. The first tests which he made show that the decomposition of Urotropin is slight and slow in neutral cold solution (68 to 77 degrees Fahrenheit), and is more active when the temperature is raised, especially on ebullition. It is also more active in acid solution, even if cold.

From these facts it would seem that Urotropin, when taken by mouth during digestion, is when it reaches the stomach in conditions favorable for the liberation of formalin, being in an acid medium at a temperature of 99.5 degrees Fahrenheit. This is easily avoided, however, by administering the drug upon an empty stomach. Urotropin is then absorbed and circulated in the fluids of the body, the blood, lymph, etc., all alkaline or at least neutral media. It does not seem probable that formalin in quantity sufficient to give a reaction will be set free in them. But when the Urotropin has been eliminated by the kidneys and mixes with the urine in the bladder, it is in an acid medium at a temperature of about 99.5 degrees Fahrenheit, *i. e.* under condi-

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\* Abstracted from the *Annals of the Royal Society of the Medical and Natural Sciences at Brussels*. Vol. XI, Part 2, 1902.

tions favorable for its decomposition and the liberation of formalin. It should therefore circulate in the blood as Urotropin and should liberate formalin only after reaching the urinary bladder.

In healthy human beings the acidity of the urine is always markedly increased by Urotropin. Formaldehyde is found in most of their urines, but here again there is no explanation for the exceptions.

When the urine is rapidly voided after excretion, it does not contain formalin. The demonstration of formalin is, however, easy, when the urine has remained three hours or more in the bladder. Hence Urotropin in man is absorbed and circulates unchanged. It is eliminated by the kidneys unchanged, and the formalin is set free only in the bladder.

From the last conclusion it follows that Urotropin may be used to set free formalin in the urine, and that it will be found useful whenever it is necessary to effect vesical antisepsis.

Vindevogel then records ten cases, in all of which the acidity of the urine, when of normal reaction, was markedly increased, and neutral and alkaline urines were acidified. Especially in chronic cystitis accompanying prostatic affections Urotropin gave good results; there was a manifest amelioration of the most troublesome symptoms, the dysuria, pollakiuria, etc. It always effects a rapid improvement followed by a complete cure in phosphaturia; success is more perfect, rapid, and permanent than under the mineral acid treatment.

Vindevogel believes also that it should render good service in cases of uric acid calculi. By keeping the urine acid and maintaining the phosphates in solution, it should prevent the increase in size of the uric acid calculus from the precipitation on it of phosphates.

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### COLLARGOLUM OR COLLOIDAL SILVER.

In a brochure on "Colloidal Metals in Medicine" (L. Simion Nf., Berlin, 1904), Dr. J. L. Beyer of Dresden gives some interesting facts regarding the history, constitution, and therapeutic action of colloidal silver or collargolum. The term colloidal des-

ignates the peculiar property of this water-soluble metal of not diffusing through animal membranes in distilled water.

Colloidal silver was first described by Carey Lea in the *American Journal of Sciences* in 1899; but his discovery was simply a laboratory curiosity without practical value, as his product was unstable and impure and had no field of application. Crede of Dresden, working wholly independently (Lea's experiments were found by him only in later researches), came to the conviction that an efficient general body disinfection could be accomplished only by metallic but soluble silver, and not by means of silver salts; and he instructed the Heyden chemical factory to make experiments in that direction. It is due to his work as well as to that of the Heyden factory, that, by new and improved processes, a stable and pure colloidal silver (collargolum) was elaborated. And it was Crede who developed the method of internal silver treatment.

Collargolum consists of small, hard, brittle, bluish-black, scale-like pieces. It is soluble in distilled water to the extent of 1:20 and remains stable even after months. Solutions may be prepared with ordinary drinking water. They may be boiled, but this is unnecessary, as collargolum is itself antiseptic. Lea's colloidal silver precipitates on being boiled.

Collargolum may be introduced into the organism by inunction, subcutaneously, by mouth, rectally, and intravenously. When given by inunction, absorption takes place in the upper layers of the corium. The dose of collargolum ointment (unguentum Crede) is one to three grams given one to four times daily. In chronic sepsis (furunculosis, puerperal fever) up to thirty inunctions may be given.

The effects of the subcutaneous injection are less rapid and certain, absorption being slow. Per os, 1:1000 to 1:200 collargolum solutions may be given in teaspoonful or tablespoonful doses two to five times daily on an empty stomach; this is especially indicated in dysentery, gastric catarrhs, etc. As an enema, 1:500 solutions are used, a cleansing clyster being given beforehand. This should be given twice daily for at least eight days. The method is praised by Prof. Schlesinger and Drs. Loebel and Kornfeld for its simplicity and safety, and because

larger doses can be conveniently administered. The action of the silver when introduced by this route is especially energetic on the neighboring organs, such as the uterus and peritoneum. But the best method is the intravenous, which is perfectly safe and is especially indicated when the blood is the seat of infection, as in endocarditis.

As collargolum is rapidly eliminated, it must be constantly supplied to the organism when a permanent effect is desired. Its efficacy is fully apparent only when the whole clinical picture, not merely temperature and pulse, is considered. In a septic process the temperature does not always correspond to the severity of the infection; and equal importance must be conceded to the general symptoms. After the use of collargolum subjective improvement almost invariably precedes temperature or pulse improvement, occurring, when given intravenously, after four to six hours, and when inunctioned after eight to twelve hours. Nervousness, headache, and stupefaction abate, the patient is relieved and refreshed, and shows more interest in his surroundings. Appetite and sleep return. Often there is a mild diaphoresis and increased intestinal activity. Collargolum directly combats the septic affection and inhibits bacterial development.

But the antiseptic has of course its limitations. It may fail to save moribund patients or those in whom the powers of heart and the vasomotors are exhausted. Nor can it affect abscesses which are out of the reach of the body fluids. Its use should be begun as soon as there is danger of the spread of a local infection.

Beyer then resumes the recent reports on collargolum by Schmidt, Wolfram, Dworetzki, Fehling, Harrison, Wenckebach, Klotz, Davydoff, Fischer, Schrage, Baracz, Arnold, Netter, and many others.

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**NEW ORLEANS POLYCLINIC.**—Sixteenth annual session opens November 1, 1903, and closes May 28, 1904.

Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. For further information, address New Orleans Polyclinic, P. O. Box 17, New Orleans, La.

## *Clinical Reports.*

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### CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

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STATED MEETING HELD MARCH 7, 1904.

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The President, Dr. James Hawley Burtenshaw, in the Chair.

#### EPITHELIOMA OF THE ORBITAL CAVITY.

This patient was presented by Dr. W. E. Lambert. Two years ago his eye became diseased, and was removed. Three weeks ago he visited Dr. Lambert's clinic. Abscesses filled the entire orbital cavity. It was opened, and a large quantity of pus evacuated. A section was made of a small indurated portion of the lower lid for microscopical examination, and it was reported to be epithelioma. The cavity was carefully explored, but no contents were found. The man had a peculiar voice, and examination revealed an opening in the hard palate which at first seemed to lead to the posterior nares, but later was found to communicate with the antrum. A section was removed from the upper portion of the antrum wall for examination. The speaker said that this was an example of a removal of a growth from the orbital cavity too late to obtain good results. Undoubtedly the abscess had invaded the cells of the antrum. If this should prove to be an epithelioma of the antrum, what could be done for it? He did not think that further surgical interference would have any effect on the growth. X-ray treatment might be of some benefit, although the progress which the disease has already made renders this doubtful. The prognosis in cases of this character is often uncertain. In one instance a patient presented himself two months after operation with induration of all the contents of the orbital cavity and a return of the disease in the lower part of his face. The induration tissue was removed, the operator

cutting as deeply as he dared, and the patient was advised to go home. Three years later he reported that he was in better condition than at the time of the second operation.

#### STRABISMUS.

Dr. Lambert also showed three cases of strabismus. The first patient had been operated on nine years ago, and soon afterward her eyes turned upward. Although there was practically no vision in the affected eye, she desired a second operation. A perfectly straight eye resulted. The second patient was a relative of the first, and her primary operation was performed at the same time. Her eyes also began to turn upward. At present there is also an immense amount of protrusion, and the vision in one eye is very much poorer than in the other. The third patient was a child who had been operated on with very good results. The position of the eye was improved, as was the vision. The speaker called attention to the three different results from one operation, and said that in the majority of these cases a very high degree of narrow refraction produces a poorer vision in one eye than in the other. The vision, however, sooner or later becomes normal.

#### STRICTURE OF THE RECTUM.

Dr. J. M. Lynch showed a specimen of stricture of the rectum, in which all the anatomical relations were preserved, showing bladder, uterus, and other appendages, and in which could be produced the tactile sensation of the stricture. It also showed the cicatrix of an ulcer which existed when the speaker first saw the patient. The ulcer rapidly healed under enemata of peroxide of hydrogen and boric acid with local applications of 50 per cent. argyrol. The patient was about thirty years of age, and gave a negative family history. Personal history of several abortions during the past ten years, peritonitis following the last one, about four years ago. She suffered from a gradually increasing and persistent constipation from infancy, relieved only by cathartics. Three years ago she was operated on for stricture, a posterior proctotomy evidently having been performed. Dilatation was not kept up after the operation, however, and the stricture returned and the constipation was as severe as before. She also

suffered from pain in the rectum and sacral region, exceeding nervousness, frequent urination, flatulency after eating, a discharge of mucous, pus, and blood with the stool, and had to strain considerably. When she first consulted the speaker, about two months ago, she was consuming large quantities of alcohol under the impression that it relieved her nervousness. She took about a pint a day, and the result was a chronic gastritis, with the usual morning vomiting which was relieved by lavage. The allowance of alcohol was limited to three ounces a day. She gave a negative history of syphilis, and there were no evidences that she had ever had this disease.

An examination of the rectum, which was exceedingly painful, showed an annular stricture some two inches above the anus. At this point the lumen of the gut was considerably diminished, not large enough to admit the tip of a small index finger; below the stricture was an ulcer about the size of a dime. An examination through the vagina above the stricture was so painful as to lead to the belief that ulceration existed above the stricture as well. Palliative treatment was useless, unless continued for the remainder of the patient's life, and the only hope of relief was in a radical operation. A resection was decided upon, and the patient was prepared for the operation by the administration of an enema of peroxide of hydrogen and boric acid twice daily for two weeks. The ulcer was healed by the application of argyrol. She commenced taking alcohol secretly in large quantities a few days before the date set for the operation, and one day suddenly expired in uremic convulsions.

#### RADIOGRAPH OF INCOMPLETE COLLE'S FRACTURE.

Dr. J. A. Robertson showed a radiograph of what is referred to by Dr. Roberts as a "rare, incomplete, reverse Colle's fracture." In addition the radiograph showed a break, which was knitted, of the styloid process of the radius and a fracture of one of the carpal bones.

#### PERFORATING GASTRIC ULCER.

Dr. J. A. Bodine reported this case. The patient, while out shopping and in apparently good health, was siezed with sudden violent pain in the abdomen and fell to the floor in a faint. She



was removed to her hotel in a cab. The speaker saw her in consultation four hours later. She had returned from abroad the day before and had always prided herself on her perfect health and energy. Inquiry as to her digestive functions brought out the fact that she had not been able to drink coffee the past few years, and that occasionally a little gas was formed in the stomach, which was relieved by a pinch of soda. There had never been any pain, vomiting or other symptoms traceable to this organ. Her pulse was 110 and temperature 99 degrees F. Her entire abdomen was rigid and sensitive to the touch; liver dullness present; tongue extremely dry, brown-coated, cracked; the typical picture of facies abdominalis present. Rupture of either the appendix, gall bladder, or stomach, was the tentative diagnosis, and immediate exploration was advised. As there had been no history of appendicitis, and as it seemed impossible for the appendix to rupture suddenly without some warning, this diagnosis was lightly considered. There had been no previous history implicating the gall-bladder, and, as in the case of the appendix, sudden, violent rupture was thought to be impossible without previous incriminating symptoms. The presence of an extremely dry, septic tongue, together with the absence of any previous symptoms, seemed to point to a perforating gastric ulcer.

A complete incision was made along the right linea semilunaris so as to cover the three organs under suspicion. Some turbid fluid escaped from the peritoneal cavity. The appendix was brought into the incision and found to be healthy. The pelvis was explored with reference to ectopic rupture and the pelvic organs were found to be absolutely healthy. The incision was enlarged upward and the gall-bladder found to be healthy. The pyloric end of the stomach was then drawn into the wound, and on the anterior surface, near the pylorus, a clean-cut perforating ulcer the size of the end of a lead pencil was found. Some gastric juice was escaping, the stomach being empty at the time of perforation. An induration, possibly an inch in diameter, surrounded the opening. On account of the condition of shock present, fancy surgery was not attempted, and the perforation was treated much as one in typhoid fever. The ulcer was inverted and buried beneath a suture. A convenient omental graft

was lightly stitched over the suture-line. The wound in the abdominal wall was closed, the gauze being brought out at the upper angle. The stomach was washed out with salt solution, to remove any contents present as well as to prevent any after-vomiting. Every two hours the patient was turned on her right side for a few moments and then again allowed to turn on her back. This was done to empty through the pylorus any mucus and gastric juice that might accumulate in the stomach. Morphine was also used in the after-treatment as a physiological splint. Nutrition has been sustained with enemas and thirst relieved by rectal saline injections. Twelve days had elapsed since the operation, the patient had been taking food by mouth about two days, and she is about well.

#### DEGENERATION OF THE CARTILAGINOUS STRUCTURE OF THE EAR.

Dr. G. B. McAuliffe showed this patient. He said that the man had received a slight traumatism which was entirely out of proportion to the changes that had taken place. Particular attention was called to the shape of the tip of the ear. The usual outline of the curves had been entirely lost. The speaker said these cases were often found in insane asylums and in institutions of a similar nature, and some authorities questioned whether a nervous lesion was not in some way connected with the condition. In the present case injections of iodine, carbolic acid, and other remedies had been tried, without result. The affection is often met with in chronic epileptics.

Dr. D. J. McDonald said that a similar condition is common among the Flathead Indians, and among others on the frontier, and in men who have been nipped by frost. The point of the ear in these cases is marked as typically as in the insane.

#### EXOSTOSES OF THE AURAL CANAL.

Dr. McAuliffe also showed specimens of exostoses which had been removed from the canal of a patient's ear. They had been grasped by a simple tenaculum, and, aided by the patient's involuntary jerk in the opposite direction, had been removed by this

instrument. The exostoses showed a small neck by which they had been fastened to the wall of the canal, which neck had not been visible while these tumors were in position.

Dr. J. H. Abraham said that Dr. Mc Auliffe was fortunate to have cases in which the tenaculum could be employed so readily. He had seen several cases of exostosis or hyperostosis, and in the majority, operative interference was contraindicated, as the patients never complained of a single symptom that could be traced to the presence of these tumors. The greater number of these growths are attached to the root and posterior wall of the external auditory canal, and in a few cases they are very close to the tympanic membrane; so near, in fact, that the operation described by Dr. Mc Auliffe is apt to prove far more serious than the presence of the tumors themselves, on account of the injury that is liable to occur to the tympanic membrane. The speaker had seen cases of exostosis in the canal in which a probe was passed with difficulty. How a tenaculum of sufficient size and strength to remove them could be passed around these tumors was beyond his comprehension. In cases in which there is an otitis media and in which the larger growths interfere with normal hearing, some operation is indicated and should be performed. A radical operation for removal, under general anesthesia, with the chisel, trephine, or other suitable instrument is the one indicated. He did not consider the tenaculum the proper instrument in such cases.

Dr. McDonald said that the method employed by Dr. Mc Auliffe was endorsed by Barr, of London, and by many other well-known authorities. They do not advocate the removal of every exostosis, but in the majority of cases, when it is possible to pass the tenaculum, they favor this procedure.

Dr. Quinlan said that these growths often exist and the attending physician and even the patient are unconscious of the fact on account of the absence of symptoms. In such cases he did not counsel their removal. He agreed with Dr. Mc Auliffe that it is much wiser to remove them with the tenaculum than to open the canal and run the risks of possible infection. Practically all of his patients with this condition of the canal had been

more or less sea-bathers, and he was inclined to think this was a factor in its development. Also, most of his patients had been men affected with uric acid diathesis.

Dr. Mc Auliffe closed the discussion, saying that he recalled one instance in which a patient was to be operated on for exostosis by opening the canal, and when the ether was administered the patient developed an epileptic attack. He was sent to the speaker to see if some relief could not be obtained without an operation, and the tenaculum was employed successfully.

The paper of the evening was read by Dr. George B. McAuliffe, the subject being

#### EARACHE.

He said that the importance of earache as a pathological symptom has grown, *pari passu*, with the discovery of the multiform sequelæ of inflammation of the middle ear. Though Nature's danger-signal, it has been too often disregarded by reason of its frequent innocuous occurrence and by the reason of the ignorance of the patient and the incapacity of the general practitioner along special lines. The lessons gained from the necroscopic examinations of brain abscesses, sinus thrombosis, and meningitis have illuminated the symptomatology of cases formerly treated for disturbed dentition, worms, gastritis, pneumonia, cerebrospinal meningitis, and malaria. Many practitioners have acknowledged that in former years cases had been treated by them under one of the above captions which now appeal to them as examples of metastases of aural sepsis.

Earache, a subjective symptom, was discussed as it appears to the general practitioner, who does not differentiate the many pathological processes of which this is the most salient symptom. Earache occurs generally at night. No explanation of this is extant. It is probably explained by the fact that while erect the pharyngeal orifice of the tube is an inch below the tympanic opening. In the recumbent position the tympanic opening is below the pharyngeal, consequently gravitation combined with weakened ciliary action of the tubal mucosa allows infection to enter the tympanum.

Bather's earache comes from the brine which is forced up into the Eustachian tube by swallowing or by clearing the nose after

coming out of the water, habits which are universal in bathers. Earache is not caused by water which enters the canal, since the drum is protected by skin which tolerates salt water. An exception to this last statement is found in persons who have a perforation in the drum. The habit of plugging the ear with a cotton protection is fatuous, except in diving.

Earache generally emanates from the nasopharyngeal infection. The importance of keeping down bacterial growth in the nose and throat during infectious diseases was illustrated by statistics. Seven per cent. of measles cases in which the nasopharyngeal cavities were attended to developed otitis media; sixteen per cent. developed otitis media when no treatment of the nose and throat was instituted.

Adenoids influence earache more by infection from their germ-laden follicles than from pressure. Besides, the adenoid tissue in the tube is sympathetically affected in attacks of adenoiditis,—the so-called coryzas of children. Blowing the nose is responsible for many earaches, especially during colds.

The amount of earache is not a guide to the amount of inflammation behind the drum membrane. The pain is felt only when the skin surface of the drumhead, which contains most of the nerves, is pushed out.

*General Treatment.* Rest in a semi-reclining position on the sound ear, with the face turned to the pillow, to favor venous return and drainage to the throat; abstention from alcohol, tobacco, and hot drinks. Tincture of aconite in the case of children one drop every hour, and for adults, aconita (Duquesnel's), 1-500 of a grain every hour until the constitutional effect is felt; no opiates; calomel; 1-10 of a grain, every hour until ten or more doses have been taken. Tincture of pulsatilla, one minim every hour or so, if profuse nasal discharge exists, is useful.

*Local Treatment.* The instillation of drugs is useless, unless when glycerine causes exosmosis or the pressure of the drops supports the bulging drum. Applications of cocaine and of adrenalin to the pharyngeal mouth of the tube relieves; dry heat, hot douches, refrigeration by ice-bag or Leiter coil for twenty-four or forty-eight hours, are beneficial and sometimes curative.

The question of incision of the drumhead was discussed from a conservative and from a radical standpoint. The writer was radical in his views because of the lack of proportion between the earache and the causal infection. He was not inclined to believe that it aborts mastoiditis. As many cases of mastoiditis occur now as in the days of conservatism. The incision in the drum should begin below, because the drumhead slopes downward and inward, and because the drumhead is less sensitive below than above. Pressure should not be exerted by the knife, since the pain of cutting results as much from tactile sensibility as from solution of continuity.

Local anæsthetics are disappointing. General anæsthesia or anæsthesia gained from compression of the carotids (Javanese method) are reliable. The after-treatment of the incision should be that prescribed by general surgery.

In conclusion the writer mentioned preventative treatment. Preventative treatment aims to diminish infection in the nose and throat during the course of infectious diseases by sprays of antiseptic oils or by applications; to treat colds in children more rigorously; to remove adenoids and a catarrhal dyscrasia by appropriate local surgery and general medical means; to interdict forcible blowing of the nose, especially during a cold; to keep the head high in children whose ears are likely to be affected; to examine frequently the ears of children who have obscure diseases or who have symptoms unusual to the disease in hand. Aural diseases may exist and the child may not appear to have earache and not know how to express or to localize pain.

Statistics show that acute otitis media is more often thought to be pneumonia than any other condition. They also show that one-third or one-half of the babies with disturbances of nutrition develop middle-ear inflammation. Therefore the ears should be examined as a routine procedure.

Dr. D. S. Dougherty opened the discussion of Dr. Mc Auliffe's paper. He emphasized the necessity of free and early incision in a case of acute otitis media. He did not advocate making the incision immediately upon the occurrence of pain or of slight reddening of the drum, but in children this might be wise. He had seen several ears affected as a sequel to measles, and in some

of them he temporized, and on looking at them the next day, found the drum had ruptured itself. He also advocated making a wide, sweeping incision, opening the flap freely.

Dr. Abraham said it had been demonstrated by Geiger and Lannoys that the normal tympanic cavity is free from bacteria. Therefore inflammations of the middle ear following sea bathing must be due to the entrance of the water into the middle ear through the Eustachian tube, carrying with it pathogenic micro-organisms from the nasal and naso-pharyngeal cavities. He thought the nasal douche the direct cause of many attacks of middle ear inflammations. The faulty method by which some persons blow the nose, holding one side and exerting pressure on the other also accounts for many attacks of otitis.

He differed with Dr. Mc Auliffe only with regard to paracentesis, and wished to add a few local applications that had proven very successful in his own work. He classified acute middle ear diseases into acute catarrh and acute inflammation and suppuration of the middle ear. In acute catarrh it is absolutely unnecessary to perform paracentesis in the majority of cases. Of fourteen cases of acute middle ear disease seen by him during the last few months, five were of a suppurative character and the others entirely catarrhal. In the former paracentesis was performed in every case, thoroughly and radically; in the remaining nine cases paracentesis was performed in only one.

Dr. Quinlan said that a hot bichloride douche of solution of mercury would soothe the ear. He said that when incision was made in the drum a smear should be made at once to see whether any infection was present.

Dr. Mc Auliffe closed the discussion, saying that while the bichloride might relieve the pain, it relieved only the outside tissue and a great deal of inflammation might go on beyond these tissues and the bichloride would have no effect whatever.

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AN EDITORIAL FOOTNOTE FROM THE DECEMBER (1903) ALKALOIDAL CLINIC.—The ancestral foundations of all the liquid antiseptics before the medical profession is Listerine; happy in name, happy in formula, and happy in time of birth. It has been, is, and ever will be, first and foremost in this field. The Lambert Pharmacal Company is to be congratulated on its success.



## ***Records, Recollections and Reminiscences.***

### **CIRCULAR LETTER FROM THE PRESIDENT OF THE ASSOCIATION OF MEDICAL OFFICERS OF THE ARMY AND NAVY OF THE CONFEDERACY.**

*Tazewell, Va., April 25, 1904.*

MY DEAR DOCTOR:—

The reunion of the United Confederate Veterans will be held in the city of Nashville, Tenn., June 14, 15, and 16., prox.

At the same time and place the Association of Medical Officers of the Army and Navy of the Confederacy will hold its annual session.

The annual meeting will be held in the Medical Department of the University of Tennessee, on Broad St., between High and Vine Sts., only three blocks from the Union R. R. Station, and will be called to order at 10 o'clock A.M., Tuesday, June 14, 1904.

#### **EXTRACT FROM THE CONSTITUTION AND BY-LAWS:**

"The object of said organization is to cultivate a friendly feeling among the members of the profession who served in the Medical Department of the Confederacy, also to collect through its members all material matter pertaining to the medical service of the Army and Navy of the Confederacy.

"All members of the medical profession who served as Surgeon, Assistant Surgeon, Contract Physician, or Acting Assistant Surgeon, Hospital Steward, or Chaplain, during the late war between the States, shall be eligible to membership as members, and the Secretary shall be instructed to enroll their names as such when application in writing is furnished, together with a statement of the official position and rank held in the Army or Navy of the Confederacy by the applicant.

"All Confederate veterans who are regular doctors of medicine are eligible to membership as Associate Members; and all sons of Confederate veterans who are regular doctors of medicine shall be eligible to membership as Junior Members."

A membership fee of one dollar shall be required of all when they become Members, Associate Members, or Junior Members,

and all shall be required to pay the sum of one dollar at each subsequent meeting they may attend. The membership fee or annual dues, must be paid before participation in any meeting of the Association.

The railroads have established a rate of one cent per mile each way, and we have positive and reliable assurance that the rates of all hotels, boarding and lodging houses will not be exorbitant or extortionate.

It behooves each member of our body to be present and aid in building up our Association, and I hope you will contribute and present some historical fact bearing on our branch of the service.

Scarcely four decades have passed since we furled our banners. Our numbers are rapidly growing less, and unless strenuous efforts are made to collect material for preservation, we will be unable to place on record the services of our noble confreres who so faithfully and conscientiously discharged their duties in those dark days that tried men's souls.

Yours truly and respectfully,  
JNO. R. GILDERSLEEVE, M. D., *President.*

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### SECRETARY'S CIRCULAR.

*Association of Medical Officers of the Army and Navy  
of the Confederacy.*

*Office of the Secretary.*

*Nashville, Tenn., April 25, 1904.*

MY DEAR DOCTOR: The Annual Reunion of the United Confederate Veterans will be held in this city June 14, 15, and 16, prox., and while every one who wore the "Gray" in the terrible four years of the great War between the States will be most cordially welcomed, to none will that welcome be warmer and more sincere than to the surviving members of the Medical Departments of the Confederate Army and Navy.

The Association of Medical Officers will hold their annual meeting at the time of the General Reunion, and Prof. Paul. F. Eve, Dean, and the faculty of the Medical Department of the University of Tennessee have offered us the use of their College

Building located on Broad Street, between High and Vine Streets, only three blocks from the Union or Terminal R. R. Station, in which to hold our meetings. The building is readily accessible and admirably suited to the needs of the occasion.

The railroads have granted a rate of one cent per mile, each way, to all who may come.

The Nashville Academy of Medicine, the local medical organization, at the annual meeting held April 5, which was largely attended, by unanimous resolution agreed to take charge of our association, and have appointed a General Committee consisting

Drs. Geo. H. Price, Paul F. Eve, Wm. G. Ewing, G. C. Track, and D. R. Neil, who will have charge of the matter, aided by such sub-committees as they may select to assist them.

The meeting will be opened at 10 o'clock on Tuesday morning, and the subsequent sessions will be so arranged as not to conflict with the other reunion features and exercises. Members of the Association and those desiring to become members, on reaching the city, are requested to come at once to the place of meeting, where members of the various committees will be found.

The work done by the commissioned and non-commissioned officers of the Medical Departments of the Confederate Army and Navy during that most remarkable epoch in the history of our great country, is to a great extent but a matter of tradition and collection on the part of the survivors, and well worthy of perpetuation on the printed page. To those who are now, or may come, members of our Association is this duty left, a duty incumbent on them for the sake of their associates who are no more, and as a legacy for their descendants and ours. All that is asked is that the true facts of our history during those days may be preserved. Will you then, my comrades, my associates, my fellow-soldiers, come and meet with us and join in this important work?

Each and every one who can come is respectfully requested to prepare a paper containing some fact of the past that he may deem worthy of perpetuation. Short, practical statements of what you may have observed at some period of your service will be most heartily appreciated. All who will prepare papers or essays are respectfully requested to inform me before June 1, by

letter or postal card, so that a program can be arranged. Your personal experiences, whether in field, in hospital, or in prison, can not but be interesting, and by doing your part you will add to the facts that have already been placed in a proper light by means of our Association. Sincerely hoping that this coming meeting may be agreeable, pleasant, and enjoyable to all who may come, I desire to remain,

Very truly and respectfully,

DEERING J. ROBERTS, M. D., *Secretary.*

208 North High Street.

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## *Editorial.*

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### ANNUAL COMMENCEMENT—MEDICAL DEPARTMENT OF THE UNIVERSITY OF NASHVILLE.

The Medical Department of the University of Nashville held its fifty-third annual commencement exercises Thursday evening March 31st, ult., in the chapel of the university. The chapel was filled with friends of the graduates, and the crowd overflowed into the halls of the building.

Prof. William G. Ewing, M. D., dean, presided. The invocation was offered by Dr. Griffin W. Bull. Prof. Alberto Hudson, M. D., delivered the faculty address. In a short talk he gave his graduating class good advice as well as good philosophy to encourage them in their chosen profession. The valedictory address was delivered by Charles Percy McCall, of Georgia.

Chancellor James D. Porter, Ex-Governor of Tennessee, conferred the degrees preceeding the ceremony by a short address, in which he said:—

"In the year 1849 the Trustees provided a Medical Department for the University of Nashville. In twelve months it was the most prosperous of the medical schools of the South, with the largest student attendance. Now, after the lapse of more than half a century, its classes are the largest of any school in the Southern Medical College Association.

"The attendance for the session now about to close was 308, one of the largest the school has ever known in spite of the fact that a full four-year course is given. The number of alumni at the close of the last session was 4,453, this being the largest number of any Southern school.

The graduating class of 1904 is as follows:—

L. G. Allexander, E. C. Bills, E. N. Blount, C. W. Brown, J. A. Bostick, R. J. Criss, W. F. Copeland, B. H. Campbell, J. W. Crawford, R. H. Draper, E. C. DeMoss, Jr., J. O. Greenlaw, C. M. Gully, L. B. Hall, M. D.

endrick, J. A. Harris, M. B. Hendrix, H. L. Horsley, H. I. Jones, J. P. ellar, H. J. Kolb, R. E. Key, E. S. Little, C. P. McCall, J. W. Morris, A. McFerrin, C. W. McDonald, W. A. McPhaul, B. F. McNeal, B. M. hillips, M. C. Ragsdale, F. E. Rehfeldt, W. C. Sizemore, L. E. Steel, F. Simpson, E. L. Saxon, W. B. Turner, E. M. Thompson, W. W. inters, S. T. Woodruff, S. F. Yoho, and C. C. York, Dr. Lonzo E. Steele, of West Virginia, won the University of Nashville edal, the presentation speech being made by Dr. Griffin W. Bull. This edal carries with it the position of interne at the City Hospital. Dr. Iwin C. DeMoss of Tennessee won second honors and was also appointed interne at this hospital. Dr. Ralph J. Criss of Mississippi, won third nors. He will be appointed interne at the Davidson County Hospital.

#### ANNUAL COMMENCEMENT—MEDICAL DEPARTMENT OF THE UNIVERSITY OF TENNESSEE.

The Medical Department of the University of Tennessee held its commencement exercises on Monday evening April 4th, ult., at Watkins Hall. The graduates received the degree of Doctor of Medicine in the presence of a large audience. A number of addresses were made by prominent members of the faculty and other distinguished men.

The exercises were opened by prayer by Dr. Griffin W. Bull, who also delivered the address to the class. Prof. S. A. Mynders, State Superintendent of Public Instruction, and Acting President of the University of Tennessee, conferred the degrees. The honor awards were made by Prof. W. E. Hibbett, M. D., and Prof. W. D. Sumpter, M. D., delivered in charge to the class on behalf of the faculty.

Dr. J. M. Miller, of Kentucky, carried off first honors. The honor carries with it the position of interne at the City Hospital for one year. The second honor was won by Dr. Oscar McMullen, of Texas, who was tendered the position of interne at the Davidson County Asylum. Dr. E. E. Taylor, of Alabama, carried off third honors.

Dr. W. D. Sumpter's charge to the graduating class was one of the most interesting features of the exercises. He took up the beginning of the art of medicine, referring to the secrets of the ancient Egyptians who possessed a knowledge of healing 4,000 years before the Christian era. Medicine had kept pace with other branches of knowledge, and diseases which were once considered incurable now yield readily to the physician's skill. The discovery of vaccination, which took the place of inoculation, marked the advancement of preventative medicine.

"There is work for you to do," said Dr. Sumpter. "Mankind in its hours of suffering needs you. To-morrow all creation is your field, and opportunity beckons to you. Be men of right living and lofty character above all else, and adding to such a life professional skill, the public will bless you and cherish your memory."

The Rev. Griffin W. Bull, D. D., said that it was appropriate that a minister address the doctors, for the two professions were kindred. He harrowed while they planted; he discussed a subject while they cut it up. The history of medical science was as interesting as a novel. Herodotus wrote of post-mortem examinations, and other classical writers were full of allusions to medical practice of the ancients. The Jews were well advanced in medical lore. In their chronicles were frequent references to healing lotions and wonderful surgery. Dr. Bull concluded his charge as follows:

"Lastly, bring Christ into your sick room. You find it often necessary to exclude the minister. And when your own time comes to pass out the portal of this life may you hear the welcome words, 'Enter ye blessed; I was sick and ye visited me.'"

Dr. W. E. Hibbett awarded the prizes to the honor men, urging them to press on to nobler things and to be a credit to their *alma mater*. Their motto should be: "Wear out" rather than "Rust out."

The graduating class was composed of J. J. Beasley, Arthur Bloom, Samuel T. Crowson, Robert A. Davis, James S. Dennison, Arlendo I. Dennison, Walter B. England, Jack R. Green, Robert S. Hern, Emmet J. Hinton, Lafayette C. Hix, L. Oscar Keen, Elijah M. Koger, Charles A. Loring, Oscar S. McMullen, J. Milton Miller, William J. O'Callaghan, Walter W. Potter, Edward G. Rappold, Whit R. Russel, Alpheus L. Sharber, J. Mack Sharat, David A. Swift, E. Ernest Taylor, Horace E. Thomas, George C. Thomas, William A. Thompson.

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#### ANNUAL COMMENCEMENT—VANDERBILT UNIVERSITY, MEDICAL DEPARTMENT.

The Vanderbilt University Medical Department held its commencement exercises in the large and beautiful hall of the Medical Building on Saturday evening, April 2nd, ult., the commodious hall being packed with an audience representing the elite of the city. The floral decorations were very handsome, and the many floral tributes awarded the members of the graduating class by admiring friends were beautiful in the highest degree.

On behalf of the faculty, Prof. Louis Leroy, M. D., delivered the charge to the graduates, impressing the young men with the highest ideals of their profession and interspersing his address with that dry humor for which he is noted.

Rev. W. R. Lambuth, a graduate of the first medical class of Vanderbilt, that of 1877, delivered the address of the evening, his theme being "The Heroic in Medical Missions." Dr. Lambuth spoke interestingly of the medical ignorance and superstition of heathens, instancing many personal experiences of his own in the China mission field. At one time he referred to the war between China and Japan and stated that Japan

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even now trying to take Port Arthur, which it had captured in 1895, and stated that a good many hoped that this attempt would be successful as the other. This evoked a storm of applause, and the speaker evidently met with the approval of the large audience present. Dr. Lambuth's accounts of many experiences aroused much laughter, particularly when he stated that after having extracted a foreign body from the eye of a Chinese woman, the woman's mother asserted that he was an angel, as no man could have done it. "I'm not an angel! I come from the United States!" was the reply Dr. Lambuth said he made. The exploits of Livingstone in Africa were also reviewed by Dr. Lambuth, who paid high tribute to his heroic efforts in the Dark Continent. Dr. Lambuth referred also to Dr. J. L. Lander, a graduate of Vanderbilt now president of a college in Brazil, and to Dr. Hector Parks, a Vanderbilt graduate, and now of Soo Chow, China, and whose great work there had resulted in his receiving Imperial permission to carry a red umbrella, have a runner ring a gong ahead of him on the high-road, and to have fireworks set off behind him to frighten away evil spirits.

Chancellor J. H. Kirkland conferred the degree of Doctor of Medicine on the graduates, and medals were awarded by Prof. W. L. Dudley, D. D., Dean of the medical department.

The Founder's Medal was won by Stanley Ross Teachout, the honor going with it an internship at the City Hospital. An internship at Madison County Hospital was awarded to John Walter Alsobrook, of Alabama. Scholarships were awarded as follows: first year, William Hays; second year, Roy Wallace Billington; third year, Paul DeLoach, of Nashville.

Dr. Alsobrook, the second honor man of the graduating class, came within one-seventh of 1 per cent. of the standing attained by Dr. Teachout, and a special medal was awarded him by Dr. W. F. Glenn.

The graduating class was composed of the following: B. C. Abernethy, W. B. Albright, J. W. Alsobrook, M. J. Barlow, J. W. Bauman, M. A. Beasley, F. L. Carpenter, A. F. Cooper, J. K. Crawford, Herbert S. Dabney, Duncan Eve, Jr., W. P. Farrington, John L. Felder, A. Grainger, C. E. Gray, John M. Lawler, J. D. Lemoine, C. F. McKenzie, W. L. Medling, J. W. Moore, E. E. Northcut, W. H. Odom, T. Polk, J. E. Jeter, W. E. Reynolds, S. L. Rowan, W. B. Singley, C. S. Strock, S. R. Teachout, S. R. Towns, G. L. Williamson, J. S. Williamson, and J. L. Wright.

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**Prescribing the products of Manufacturing Pharmacists, we should be guided to a great extent by the business standing of the manufacturers. No house in the land has a better reputation for strict integrity than that of Robinson—Pettet Co., of Louisville, Ky. Their preparations are perfectly reliable.**



## ANNUAL MEETING OF THE NASHVILLE ACADEMY OF MEDICINE.

The meeting was held in the Assembly room at 8 o'clock on the evening of Friday, April 5, ult., about one hundred members being present.

The annual address of the retiring president, Dr. D. B. Blake, was read and the following officers chosen: President, Dr. S. S. Crockett; Vice-President, Dr. Louis LeRoy; Secretary and Treasurer, Dr. Deering J. Roberts. Drs. R. E. Fort, D. B. Blake, and A. B. Cooke were chosen as delegates to the convention of the State Medical Association at Chattanooga.

The Association decided to take care of the Association of Confederate Medical Officers during the reunion in June.

At the close of the business session, the members repaired to the dining room of the Tulane, where a very appetizing, elaborate, and tasty *menu* was placed before them by the efficient and courteous manager of the hotel, Mr. Jones.

The newly elected president, Dr. Crockett presided as toast-master in a most efficient and capable manner. Gov. Jas. B. Frazier, Mayor A. S. Williams, and Dr. W. Frank Glenn, who were first on the list for responses, being absent, Dr. Deering J. Roberts was called on to reply to the subject assigned to Dr. Glenn, "The Appendix." His remarks were brief, but pointed, and were well received.

Dr. A. B. Cooke responded to the toast, "Legislation and the Medical Profession." Dr. Cooke referred to the opposition which came from the people whenever legislation was attempted which had for its end the protection of health. He scored what he called an abuse of the advertising columns of the newspapers in putting into the hands of the youth and the young girls advertisements of specialists which contained suggestions and facts which tended to demoralize those who read them, and he urged that legislation be enacted preventing the publication of such matter.

Dr. George H. Price kept the guests in one continuous laugh on the subject, "Sore Toes," referring to it as a bar to progress, and including in his response the sore toe of the boy, the wealthy old man, and social, commercial, political, and professional sore toes. He said he hoped every physician present had a sore toe over the treatment accorded them by the Carnegie Library.

Dr. J. C. Pryor, U. S. N., who has been on duty at Panama, and is en route to Washington under orders, spoke briefly of "Panama and Pajamas." Dr. W. H. Witt spoke on "The Umbilicus," in a humorous vein, after which the assembly adjourned, thus concluding a very pleasant and enjoyable evening, and the most successful year in the history of the organization.

**WHEN YOUR CASE IS WEAK ABUSE THE OTHER SIDE.**—This maxim has been a favorite standby with the legal profession from time immemorial and unfortunately certain pharmaceutical manufacturers have recently seen fit to make use of this maxim. This is particularly true of the manufacturers of a certain iron preparation. The impudence and effrontery with which these people try to hoodwink the medical profession is rather remarkable.

No other preparation ever came before the medical practitioner with so little detail as to methods of preparation, composition, therapeutic effect, etc., etc., and nevertheless the profession is asked to accept the wildest and most extravagant statements as to its wonder-working capabilities. This is not all. The makers of this preparation, in seeking the support of the profession covertly attack and sling mud at all other iron preparations that have been before the profession for years. They single out Pepto-Mangan, a combination which has stood the tests of the leaders in the scientific medical world both here and abroad, an organic iron combination in which, in its results, the general practitioner and the hospital clinician have learned from experience to place implicit confidence.

This unbusinesslike method of attempting to cast discredit upon other reliable and thoroughly tested combinations we can not term otherwise than despicable, and furthermore we know our readers can not be influenced by unsupported statements of financially interested parties, but will always bear in mind that Gude's Pepto-Mangan was submitted to the profession as an organic iron product, and the results obtained by its use, as also the scrutiny of analysis by chemists of repute, substantiate what has ever been claimed for it.

Attempting to foist upon the attention of the physician a product simply by insinuation that known articles are inferior, is a manner of doing business which should receive the stamp of disapproval by every one in our profession.—*Editorial in the Toledo Medical Journal, April, 1904.*

**IN SPITE OF TEACHERS AND TEXT-BOOKS**, the days of the cotton jacket and the linseed poultice seem to be past. Perhaps the applications valued most highly by medical teachers at this time are the cold ones either in the form of ice-bags or cold compresses frequently changed. These when placed over the seat of disease, seem to give decided relief, to modify the temperature, and to hasten early resolution. But in spite of their advocacy in the text-books, the rank and file of the profession do not take to them kindly.

Antiphlogistine now enjoys perhaps greater popularity in the treatment of pneumonia and other acute respiratory diseases than any other local application. This popularity seems to be well-deserved. It may not modify the course of the disease to any great extent, but it certainly gives of the greatest comfort to the patient, and helps to ameliorate

some of the troublesome symptoms which are characteristic of the disease. Antiphlogistine must therefore be considered a distinct addition to our therapeutic armamentarium.—*The Medical Standard, March, 1904.*

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DYSPEPSIA AND MAL-ASSIMILATION are two factors, which are bridges which must be crossed before we can get good results in any case. To cure dyspepsia, some one remedy is best, provided that one remedy acts on all kinds of food. A one-sided digestive ferment will not produce the results we desire, and so a reliable remedy must be found. As before said, Peptenzyme has been found easy, both for infants and adults. The remedy can be given with great freedom as regards dosage, as it is entirely non-toxic.—*Medical Progress.*

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## *Reviews and Book Notices.*

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OBSTETRICS FOR NURSES. By Joseph B. De Lee, M.D., Professor of Obstetrics in the Northwestern University Medical School, Chicago; Lecturer in the Nurses' Training Schools of Mersey, Wesley, Provident, Cook County, and Chicago Lying-in-Hospitals. 12 mo. of 460 pages, fully illustrated. Philadelphia, New York, London. W. B. Saunders & Co., 1904. Cloth, \$2.50 net.

Although this work was written, as the author states, primarily for nurses, yet from our interesting examination of it we firmly believe that medical students will find in it much of value, since the duties of a nurse often devolve upon him in the early years of his obstetric practice. There are really two subjects considered—obstetrics for nurses and the actual obstetric nursing—and Dr. De Lee has combined them so that the relations of one to the other are natural and mutually helpful, presenting this important branch of medicine in a clear and interesting form. The illustrations have not been borrowed from other works, as is too frequently the case, but have been made expressly for this book. The photographs were taken by the author from actual scenes, and are true to life in every respect. The text is the outgrowth of eight years' experience in lecturing to the nurses of five different training schools.

**ATLAS AND EPITOME OF OPERATIVE GYNECOLOGY.** By Dr. O. Schaffer, of Heidelberg. Edited, with additions, by J. Clarence Webster, M.D. (Edin), F.R.C.P.E., Professor of Obstetrics and Gynecology in Rush Medical College, in affiliation with the University of Chicago. With 42 lithographic plates in colors, many text cuts, a number in colors, and 138 pages of text. Philadelphia, New York, London. W. B. Saunders & Co., 1904. Cloth, \$3.00 net.

This new addition to Saunders' admirable series of Hand-atlases is excellent. It is unfortunate that medical students graduating each year know less about gynecologic operations than about almost any other department of operative surgery. This atlas, therefore, is opportune, and the excellence of the lithographic plates and the many other illustrations render it of the greatest value in obtaining a sound and practical knowledge of operative gynecology. Indeed, the artist, the author, and the lithographer have evidently expended much patient endeavor in the preparation of the water-colors and drawings. They are based on hundreds of photographs taken from nature and reproduce faithfully and instructively the various situations which they intend to illustrate. The text closely follows the illustrations, and we have found it fully as accurate. We consider it of great value to the up-to-date practitioner and surgeon, as well as to the specialist.

**COMPEND OF PATHOLOGY, GENERAL AND SPECIAL.** A Student's Manual in One Volume. By Alfred Edward Thayer, M.D., Professor of Pathology, University of Texas. Second edition; 8vo.; flexible morocco; 711 pages, with 131 illustrations. P. Blakiston's Son & Co., Publishers, 1012 Market Street, Philadelphia. 1903.

Prof. Thayer's two most excellent Compenda of Pathology are here combined in a single volume. This we regard as a decided improvement on even such an excellent presentation of pathology that met with such favorable reception in the recent past. The subject is presented clearly, with ample completeness for the needs of the student, and it will prove a most valuable and handy little work for the practitioner when he has not time for consulting more extensive treatises. Controversial matter and reference to authorities are omitted. A new chapter on the nervous system and several illustrations have been added, and the text has been thoroughly revised in the volume before us. The publishers have most fittingly and admirably brought out the work, its beautiful, flexible binding is appreciated.

**DISEASES OF THE INTESTINES.** A Text-Book for Students and Practitioners of Medicine. By Max Einhorn, M.D., Professor of Medicine in the New York Post-Graduate Medical School and Hospital, and Visiting Physician to the German Hospital, New York. Second edition; revised; 8vo., cloth; 397 pages. Price, \$3.00 net. Wm. Wood & Co., Publishers, New York. 1904.

Diseases of the stomach and diseases of the intestines have given Dr. Einhorn a strong hold on the reading members of the profession. This work is a continuation of his treatise on diseases of the stomach, the two cover the principal disorders of the digestive system. The practical and important fields of diagnosis and treatment are fully and practically considered. The first edition, issued only a little over three years ago, being exhausted, a new one has been published, which we feel confident will meet with the same favorable reception won by its predecessor.

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## *Selections.*

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**THE CAUSE AND TREATMENT OF CANCER.**—Another alleged discovery of the cause of cancer has been recently added to the already long list of such happenings, and has been, as usual, widely heralded by the lay press. In addition to this announcement the statement is made that a specific treatment of the disease has followed as a sequence the isolation of the causative parasite. Dr. Otto Schmidt, of Cologne, is the author of these reputed discoveries. A striking evidence of the intense interest which is taken by the medical profession in any reported new facts concerning malignant disease has been afforded by the dispatch to Cologne of a London specialist with the view of learning all that was to be learned of Dr. Schmidt's theories and methods. On November 5 Dr. Jossé Johnson delivered an address before the Abernethian Society at St. Bartholomew's Hospital, which is reported in full in the *London Lancet*, November 14, in which he presented the result of his observations on Dr. Schmidt's specific treatment of cancer. So far as the isolation of the parasite is concerned, it would seem that the one found by Dr. Schmidt resembles in its essential details those first

described by Russell in 1890 and afterwards by several investigators. But the German scientist has not offered sufficient evidence to prove clearly that he can be regarded as the discoverer of the cause of cancer. After all, however, by far the most important part of Dr. Schmidt's statements is that in which he claims to have discovered a method of treatment which inspires the hope that at length a cure for the malady has been found. The rationale of treatment, according to Dr. Johnson, is twofold: First, active immunization—that is, by the injection of cultures, fourteen to twenty-one days old, which have been first killed by the application of heat (65 C); and, secondly, passive immunization, by the injection of the serum of immunized animals—sheep and horses—into the subcutaneous tissues of the patient. The result of active immunization which follows injections into the body of cancerous patients is asserted to be a specific reaction in the tumor and affected parts. Injections of the cultures into a healthy subject or into one suffering from any other disease produced no symptoms whatever. If, on the other hand, the cancerous process is in the body, then a specific reaction supervenes, whenever there is any recuperative power in the blood of the patients. The "vaccine," in addition to its curative effects, possesses, so it is claimed, another valuable quality, one of great use in diagnosis. Although cachectic patients hardly react at all to the "vaccine," it is said that innocent growths can be accurately diagnosed from malignant ones and likewise metastatic deposits can be detected. With regard to the action of the serum upon patients afflicted with malignant disease, the speaker was not so enthusiastic as when referring to the results produced by the vaccine. He says it has the drawbacks of all serum injections, and that to be effective its unit value will have to be much raised. In the discussion that followed Dr. Johnson's address the optimistic conclusions reached by the speaker were criticised, and it seemed to be the opinion of the majority of those present that these conclusions were not warranted by the evidence thus far adduced by Dr. Schmidt, and that, indeed, the public announcement of the result of his investigations was, to say the least, premature. The *Medical Record* on several occasions has deprecated the now prevalent custom of announcing as *bona fide* original discoveries theories founded upon researches which have not been

so thoroughly carried out as to justify a positive statement. Cancer cures are advertised in the lay press with a frequency that is both astonishing and nauseating, and any announcement such as that just made by Dr. Schmidt is seized upon by the sensational newspapers with avidity and enlarged upon and distorted with the exuberance of imagination characteristic of present-day journalists. With the distressing outcome of the publication in the lay journals of the curative effects of Koch's tuberculin, still green in the memory, no one—with such an example before him—can deny that infinite caution is needed in dealing with these matters.—*New York Medical Record*.

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**THE GERMICIDAL ACTION OF ALCOHOL.**—Drs. Harrington and Walker (*Boston Medical and Surgical Journal*) have studied the germicidal action of alcohol, and conclude that: (1) Against dry bacteria, absolute alcohol and ordinary commercial alcohol have no germicidal power even with twenty-four hours' direct contact, and other preparations of alcohol containing more than seventy per cent, by volume, are weak in this regard, according to their content of alcohol—the stronger in alcohol the weaker in action. (2) Against the commoner, nonsporing, pathogenic bacteria in a moist condition, any strength of alcohol above forty per cent, by volume, is effective within five minutes, and certain preparations within one minute. (3) Alcohol of less than forty per cent strength is too slow in action or too uncertain in results against pathogenic bacteria, whether moist or dry. (4) The most effective dilutions of alcohol against the strongly resistant (nonsporing) bacteria such as the pus organisms, in the dry state, are those containing from sixty per cent to seventy per cent, by volume, which strengths are equally efficient against the same organisms in a moist condition. (5) Unless the bacterial envelope contains a certain amount of moisture, it is impervious to, strong alcohol; but dried bacteria, when brought into contact with dilute alcohol containing from thirty per cent to sixty per cent of water, by volume, will absorb the necessary amount of water therefrom very quickly, and then the alcohol itself can reach the cell protoplasm and destroy it. (6) The stronger preparations of alcohol possess no advantage over

sixty per cent to seventy per cent preparations, even when the bacteria are moist; therefore, and since they are inert against dry bacteria, they should not be employed at all as a means of securing an aseptic condition of the skin. (7) Provided the skin bacteria in the deeper parts can be brought into contact with disinfectants, alcohol of sixty per cent to seventy per cent strength may be depended upon usually, but not always, to destroy them within five minutes. —*Charlotte Medical Journal*.

THE BORDERLAND OF DIPHTHERIA AND SCARLET FEVER.—A recent paper by H. E. J. Bliss in the *Lancet* discusses this question from a broad standpoint. The author comments on the rigid nosology of the present day, which, he says, is a period dedicated rather to the apotheosis of the systematic rather than to the philosophical contemplation of morbid phenomena. He states his desire to discuss the conditions that lie between those aggregations of morbid symptoms which we call, for convenience's sake, scarlet fever and diphtheria. These are diseases, he says, which resemble now one of the two and now the other, but yet fade away to a sort of neutral zone, leaving us in doubt as to the exact category under which they ought to be placed. A similar illustration is the so-called "fourth" disease of the measles-rötheln-scarlet fever group. The only justification for the creation of a new disease is the erection of a fresh and sufficiently distinctive criterion to which reference may be made in cases of doubt. Such criteria are constantly shifting their ground as our knowledge increases. Absolute truth is merely an ideal and not an attainable finality. As a matter of fact, diphtheria, scarlet fever, and tonsillitis, using those terms in their broadest sense, afford many examples of departure from their respective types, and at times insensibly merge one into another. Various forms of tonsillitis present rashes, and the author calls attention to the necessity in every case of sore throat of making a routine examination of the skin. He states that he has been vividly impressed with the frequency with which erythemata of all kinds, shapes, and distributions occur in these circumstances. From a little mottling of the chest to the most intense general blush such rashes vary, and over and over again scarlet fever has been suspected where it did not exist. On the other hand, it is quite possible that many of these cases have been mild ones of scarlet fever, in



which the diagnosis has never been cleared up. The distinction is not possible with our present equipment. Another confusing class of cases is made up of sore throats attended with deep ulcerations. They are not frankly diphtheria or scarlet fever, but they run a severe course and are occasionally fatal. Their chief feature is the presence of a large ulcer or ulcers on the tonsils and surrounding tissues, some of considerable extent and depth; the adjacent lymph glands are inflamed, and there are fever and general constitutional disturbance. The local process sometimes leads to considerable destruction of the throat tissues, and the system may become infected by the pyogenic cocci. The great difficulty at first is the distinction of these cases clinically from diphtheria, which they resemble strongly in the throat appearances. When this difficulty is disposed of by the progress of the case, the suspicion of scarlet fever begins and is often, indeed, present to the end, so similar are the later lesions of the fauces and palate. The general symptoms, too, are of the sthenic type—delirium, restlessness, and considerable pyrexia—which suggest a much closer relationship to the latter disease than to the adynamic, algid diphtheria. Bliss believes that an actual coincidence of diphtheria and scarlet fever is very rare. One may overlap the other—that is, the symptoms of one may appear and progress while the symptoms of the other are fading away. He relates several clinical histories illustrative of the various points made in his paper; and while emphatically discountenancing vagueness in diagnosis, recognizes that there may be cases in regard to which equally competent men may differ. The bacteriological test is not absolute, for as diphtheria bacilli are found in the throats of healthy persons, so also they may be found in the throats of scarlet fever patients, and their mere presence does not justify the diagnosis of diphtheria. The fact remains, then, that the shadings between these two diseases and some of the severe forms of tonsillitis are so gentle that each shades off into the other not at one but at many points, and whilst this continues to be so, with the most consummate skill and the widest experience, the diagnostician can never attain a certainty in his art which its inherent disabilities forbid.—*New York Medical Record*.

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**X-RAY THERAPY—ITS LIMITATIONS.**—In a very excellent paper read before the Brooklyn Pathological Society in De-

cember, edited by John A. Lee, M. D., and published in the Brooklyn Med. Jour. in February, he concludes with the following summary :

All epitheliomas, no matter of what type, will show a very high percentage of apparent cures. I believe, even in epithelioma of the cervix, we can, in some favorable cases, confidently expect a satisfactory result. The reason seems to be, to my mind, because these growths are on or adjacent to the skin surface, hence more easily acted upon; because of the slight tendency to metastasis and the generally well marked circumscribed area of the disease.

To my mind, in all epitheliomatous conditions it will be the treatment of choice and will be the means of saving many cases. In all operable cancers, surgery should still be the treatment adopted. Not because the surgical result is always satisfactory, but the X-rays may be positively dangerous, since in the breaking down of the tumor, many undestroyed cancer cells may be carried by the lymph channels to other parts of the body, especially to the glands, developing oftentimes a metastasis where none previously existed. This is especially true in large breast cancers.

In small breast scirrhus, when for any reason surgical operation is contraindicated, I believe X-ray treatment might be instituted with favorable expectations. On the other hand, in all large cancers the more removed by the knife and the less disease left to combat with the X-ray the more successful will be the outcome.

It is just this class of cases, operable cases with post-operative treatment, that there is a large field for future investigation.

It is questionable whether all cases should not be submitted to the influence of the rays directly after operation and before the liver becomes studded with nodular growths. It might be argued that, in these cases, we could not refer successful results to the benefit of the rays. That, in part, is true, but we now know what the general outcome is without X-ray treatment.

In the class of recurrent cancers, suitable cases, properly treated, will not show the unsatisfactory results which I have been forced to detail. While my preference has been given to surgery in primary growths, it has always been my belief that

there has always been too much surgery in recurrences, surgery which I do not believe has even the doubtful advantage of prolonged life.

Recurrences along the scar, either ulcerative or of the type known as "en curiasse," are favorable for X-ray treatment and will give satisfactory results. Hardened, pea-like glands in the supraclavicular region will readily submit to X-ray influence. Large masses of glands in any position are less favorable because systemic involvement is generally very rapid. The time to treat a recurrence is when a recurrence is recognized, and no time should be lost, for, even then, it may be too late. Patients operated upon for cancer should have a monthly examination, at least, for the first year, and this necessity should be impressed upon them.

When a patient begins to show involvement, either in liver or lung, I do not believe it worth while to institute a course of treatment.

Rapid recurrences in tumor growths should not be treated. In these cases the disease is virulent, metastasis positive and uncontrollable.

In inoperable carcinomas there must likewise be a large percentage of failures, but it is here that we can also obtain our most brilliant results. Many of these extensive ulcerative growths, formerly hopeless, will be saved.

Exceedingly vascular tumors or cases with a short history, rapidly progressing, are improper for treatment.

It may be stated as an axiom in X-ray therapy: The more acute the disease, the more hopeless it is; the more chronic the condition, the greater is the possibility of cure.

I believe the X-ray cannot prevent or affect a metastasis, and as a palliative measure should be employed only in the presence of pain. It is better than morphine and has none of morphine's disadvantages.

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THE SURGICAL TREATMENT OF EARLY DIAGNOSED CANCER OF THE UTERUS.—J. E. Janvrin concludes that in about one-third of all cases of uterine cancer, involvement of the regional glands in the pelvis takes place. This involvement rarely occurs in the incipient stage, and abdominal radical operation with the removal of the pelvic glands lessens the high percentage of recurrences.—*American Gynecology*.

**TREATMENT OF ANGINA PECTORIS.**—William H. Waugh treats this disorder by giving glonoin, 1-250 of a grain every minute until the face flushes. This effect is deepened and prolonged by giving atropine, 1-250 of a grain, every ten minutes until the mouth begins to dry. There will be no attack as long as this effect endures, and the effect may be definitely prolonged by repeating the atropine whenever the dryness of the mouth subsides. On the theory that spasm betokens weakness, strychnine, 1-130 of a grain, every fifteen or thirty minutes, may be administered until the pulse regains its normal tonicity. In the absence of the remedies advised, anything that will bring the tears to the eyes will break the attack. Alcohol in any shape, volatile oils, ammonia, camphor, pepper, ginger, or any other spice or ether given hot and in concentration will answer. In the interval the mental and physical welfare should be attended to.—*Therapeutic Gazette.*

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**SPLANCHNOPTOSIS.**—While the diagnosis of Glenard's disease in its full extent, or when limited to nephroptosis, is now usually made without much difficulty, its treatment still continues to be a matter of great dispute. Experience has demonstrated that a pad and belt, or even the more complicated appliances, fail to hold the prolapsed organs unless undue pressure is used, or the condition be one of very mild degree. Continued, severe pressure, preventing the normal movement and function of the muscular structures involved and taking away all work from the supporting ligaments, can have but one effect—that of atrophy. As the primary condition is one of atrophy, with the resultant relaxation, it would appear that this line of treatment was one of aggravation, and therefore contraindicated.

The surgery of splanchnoptosis in every phase is practically without mortality, the after-treatment one that will add tone to the abdominal walls and leave the patient in comfort instead of being burdened with a continual pressure. By firm suturing the danger of hypertrophy, followed by degeneration, is avoided, to say nothing of the complications that often call for surgical intervention at a time and place when operative measures threaten sepsis, with its train of evils.—H. A. I., in *Cincinnati Lancet Clinic.*

# Listerine

**Non-toxic, Non-irritant, Non-Escharotic Antiseptic.**

**Absolutely Safe, Agreeable and Convenient.**

Listerine is a well-proven antiseptic agent—an antizymotic—especially useful in the management of catarrhal conditions of the mucous membrane, adapted to internal use, and to make and maintain surgically clean—aseptic—all parts of the human body, whether by spray, injection, irrigation, atomization, inhalation, or simple local application.

Listerine is a swift and sure destroyer of infusorial life; it prevents the various fermentations, preserves animal tissues and inhibits the activity, growth and motion of low forms of vegetable life: hence Listerine may be relied upon to destroy the activity of the living particles which constitute contagion whenever brought into intimate contact therewith.

**For diseases of the uric acid diathesis:**

## Lambert's Lithiated Hydrangea

A remedy of acknowledged value in the treatment of all diseases of the urinary system and of especial utility in the train of evil effects arising from a uric acid diathesis.

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Descriptive literature may be had upon application to the Manufacturers—

**LAMBERT PHARMACAL CO.,**

**St. Louis, U. S. A.**

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**Be assured of genuine Listerine by purchasing an original package.**

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## ***Prescriptions and Formulary.***

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### **SUBACUTE GOUT.**

The following combination is recommended by The Pract. in the treatment of subacute gout:

R. Colchicin.....gr. 1-60  
Ext. nucis vom .....gr. 1-4  
Ext. gentianae..... gr. 1

M. Ft. pil. No. 1. Sig.: One such pill three times a day.

As a local application for gouty joints the following is recommended by Clemens in Amer. Med.:

R. Sodii carb.....dr. iii  
Tinct. opii.....oz. ii  
Linimenti bellad.....oz. ii  
Aquae q. s. ad.....oz. viii

M. Ft. Unimentum. Sig.: Mix with equal parts of hot water and apply locally to the affected joint on a cloth and cover with oiled silk.



They are unsurpassed as a positive and speedy cure for Diseases of Women. They have been successfully prescribed by Physicians for ten years. We have increased the size of boxes from 25 to 100, which we are selling at the same price, \$1.00 per box, which puts them in the reach of every Physician for office use. Send for samples and literature.

**NAPHEY & CO.**

**Warren, Pa.**

#### INTESTINAL ANTISEPTIC IN CHILDREN.

R. Benzo-naphthol ..... 0.05 cgm.  
 Bismuthi Salicylat (basic)..... 0.10 cgm.  
 Bismuthi Bicarbonat. (basic)..... 0.10 cgm.

For one powder. Make five such, and give one every two hours to a child of five or six months of age.

#### DIURETIC FOR CHILDREN.

R. Potassium Acetate.....  
 Potassium Nitrate.....aa gr. xv.  
 Oxymer of Squill.....  
 Comp. Syr. of Sarsaparilla.....aa dr. iss.  
 Infusion of Juniper Berries.....oz. ss-oz. iiss.  
 S.: To be taken during the day.

#### AN EMULSION FOR BURNS, INFLAMMATORY PHIMOSIS, BALANOPOSTHITIS, ETC.

Ullmann (Press Medicale) strongly recommends the following:—

R. Tannoform.....75 grains.  
 Solid White Paraffin.....75 to 150 grains.  
 Liquid Vaseline.....1,275 to 1,350 grains.

#### TO ABORT PNEUMONIA IN CHILDREN.

The following was successful in a child of eleven years:—

R. Tinct. Verat. Virid. (Norwood).....gtt. vj.  
 Tinct. Aconiti Rad.....gtt. ij.  
 Aq. Destill.....  
 Syr. Tolutan.....aa oz. ss.

M. S.: Teaspoonful every half hour for five doses, then a teaspoonful every hour.

#### RACHITIS.

R. Phosphori ..... 0.01 cgm.  
 Ol. Morrhuæ..... 1,000 gm.  
 Saccharin ..... 0.10 cgm.







### RHUS TOXICODENDRON POISONING.

The following combination is recommended by Med. Pharm. Critic and Guide in the treatment of ivy poisoning:

R. Sodii hyposulph.....oz. i  
Menthol.....gr. v  
Alcoholis.....dr. i  
Spts. etheris nitrosi.....oz. i  
Aq. destil. q. s. ad.....Oj

M. Sig.: Apply locally with a soft sponge or on sterilized gauze.

### PNEUMONIA.

The use of calomel in pneumonia has been recommended by L. Bertazzoli in Med. News. Although he does not consider his preparation as a specific, it should be administered in generous doses, and should be accompanied by such other drugs as provoke energetic peristalsis so as to procure its elimination from the organism rather than be absorbed. He, therefore, administers it combined with scammony because of the latter's effect on the intestine. The calomel produces anti-cretic effects and seems to cut short the further spread of the inflammatory process. The headache is also relieved, as well as the delirium. It is also a good diuretic and a reliable disinfectant.

To lower the temperature and pulse in pneumonia, the following combination containing sodium salicylate is recommended:

R. Sodii salicylatis.....dr. i  
Syr. simplicis.....dr. iiii  
Aquae q. s. ad.....oz. vi

M. Sig.: One tablespoonful every hour until the patient perspires freely.

To relieve the cough and pain in pneumonia Danforth, in Applied Ther., recommends the following combination:

R. Codeinae.....gr. ii  
Liq. ammon. acetatis  
Spts. chloroformi, aa.....dr. iv  
Syr. lactucarii q. s. ad.....oz. ii

M. Sig.: One teaspoonful every hour.

As a substitute for the foregoing prescription the codein may be combined with camphor or ammonium carbonate in order to stimulate the functions of skin.

# THE ANÆMIAS

yield readily to organic, or true animal iron treatment.

A resort to *inorganic* iron preparations or tonics, serves only to stimulate corpuscular proliferation without supplying sufficient nutrition to mature the blood cells.

A preparation of **TRUE ANIMAL IRON** that will supply every deficiency in the blood, and assure the proliferation of *all* the corpuscles to a full and sturdy maturity, is found in

## BOVININE

It contains 10% **ANIMAL IRON**, 20% coagulable albumen, and every element of nutrition of the animal, mineral, and vegetable kingdoms.

It is readily absorbed by the tissues, requires little or no digestion, is prompt and reliable in stimulation and support, and is a nutrient of the very highest value.

**BOVININE** administration causes quick increase of the leucocytes, and a consequent arrest of all pathological processes.

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A postal request brings you our Hand-book on Haemotherapy, giving valuable information to both the general practitioner and the specialist.

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## DR. PETTEY'S RETREA

FOR THE TREATMENT OF

### ALCOHOL AND DRUG ADDICTIONS

Methods employed render the morphine addiction the  
certainly and readily curable of all the chronic ailments

GEO. E. PETTEY, M. D., 958 Davis Ave. Memphis, Tenn.

tage of resolution, if cough is troublesome, so  
mixture similar to the following is recommended:  
ph. sulph.....gr. i  
mon. carb.....dr. i  
ae camph.....oz. i  
pruni virg.....oz. ii  
p.: One teaspoonful every three hours.

#### BRONCHO-PNEUMONIA.

ng combinations are recommended in Clin. The  
ent of catarrhal pneumonia:

nonii chloridi.....gr. lxxx  
scillae.....dr. iii  
ammon. acetatis q. s. ad.....oz. iv  
mistura. Sig.: One dessertspoonful in wa  
four hours.

drops of the tincture of aconite may be added  
he foregoing, carefully watching its effects; or  
non. carb.....gr. xlv

fl. acaciae  
api simplicis, aa.....oz. ss  
t. lavendulae comp.....dr. ii  
ae q. s. ad.....oz. iv  
p.: One teaspoonful in water every three hou  
ears of age.

here there is threatened respiratory failure t  
be substituted:

l. sulph.....gr. xxiv  
ch. sulph.....gr.  $\frac{1}{2}$   
li hydrochlor. dil.....m. xv  
erini.....dr. iii  
pepsini q. s. ad.....oz. iv  
p.: One teaspoonful in water every three or fo  
uld 5 years of age; or:

ch. sulph.....gr.  $\frac{1}{2}$   
li hydrochlor. dil.....dr. i  
l. chloroformi.....dr. iv  
cinchonae liq.....dr. iii  
ae q. s. ad.....oz. iv  
mistura. Sig.: One teaspoonful for a child  
every three or four hours.



### CREOSOTAL IN CROUP.

Lazansky, in Med. Council, recommends the following combination containing creosotal in the treatment of croup contracted by children between the ages of 5 and 10 years:

R. Creosot.....gr. xlv- dr. i  
 Liq. ammon. anis.....m. xv  
 Syr. senegae.....oz. ss  
 Infus. ipecac. rad.....oz. iss-iii

M. Sig.: One teaspoonful every hour until fever diminishes, then every two to three hours.

### EMPYROFORM.

Skarlek, according to an abstract in Amer. Med., has found empyroform to be beneficial in the treatment of eczema. It lessens the itching, has marked drying properties, and is non-irritant. It is useful in all stages of eczema. He employs the following combination:

R. Empyroform.  
 Pulv. amyli, aa.....dr. vi  
 Lip. petrolati.....oz. iss  
 M. Ft. unguentum. Sig.: Apply locally.

Empyroform is a combination of tar and formaldehyd. It is brown powder with tar-like odor, insoluble in water but soluble in caustic alkalies and chloroform and liberates formaldehyd when heated.

### PERTUSSIS.

The following combination is recommended by J. S. Howard, Med. Council, in the treatment of whooping-cough:

R. Acidi nitrici dil.....oz. i  
 Tinct. card. co.....dr. iii  
 Syrupi simplicis.....oz. iiss  
 Aquae .....oz. i  
 M. Sig.: One small teaspoonful every two hours.

The foregoing is especially recommended in infants, who have been exposed to the disease, as a prophylactic measure.

THE BEST RE-CONSTRUCTIVE—  
**Phillips' Phospho-Muriate of Quinine, Comp.**  
(The Soluble Phosphates with Muriate of Quinine, Iron and Strychnine.)  
PERMANENT—Will Not Disappoint,      PHILLIPS', Only, is Genuine,  
THE CHAS. H. PHILLIPS CHEMICAL CO., 128 Pearl St., New York

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No. 6

### *Original Communications.*

#### THE RELATION OF THE GENERAL PRACTITIONER TO INSANITY.\*

BY M. CAMPBELL, M. D., OF KNOXVILLE, TENN.

When I was requested by your Committee to prepare a paper on the above subject, I complied very willingly, because I consider it unfortunate that there is a disposition on the part of the majority of the general practitioners to neglect the study of insanity more than any other department of medicine. This doubtless arises from the difficulty of treating the disease elsewhere than in a hospital especially fitted for the reception of the insane. The insane are more cheerfully turned over to the specialist, than those suffering from any other form of disease. However true this may be, I do not think the reason is sufficient

\* Read at the Annual Meeting of the Tennessee State Medical Association, April 14, 1904.

## THE SOUTHERN PRACTITIONER.

g the study of so serious and common a disease. ntion of disease is more important than its cure; this true of insanity, and it goes without saying a knowledge of its causes. the immense influences d practitioner in preventing this disease will be lost. e physician, who in a given case of mental disease ke a diagnosis and prognosis; and order a line of ill find his knowledge to his own advantage, as well tients; to the patients, if for no other reason than ten impossible to get them admitted in a hospital. osis and prognosis of insanity, in the majority of more difficult than in other forms of disease. As ite, some knowledge of classification should be ob- classical mania, melancholia, and dementia, of iliar to you all. The objection to this classification s not include in its three groups, all forms of mental that it is symptomatic only, telling nothing of the athological conditions; these conditions may, in one e the symptom of mania and, in another, that of or they may alternate; and further, the symptoms d melancholia may indicate different pathological me kind curable and another not. Nevertheless, e useful, and should not be abandoned.

of this paper will not permit me to go into an assification that will include all forms of insanity, call your attention to certain prominent groupings, e are easily recognized.

hen, simple mania, characterized by excitement, inability and restlessness, with rapid ideation, and sions.

a simplex, characterized by profound depression, a, with delusions of unworthiness and impending

a agitata, in which there is accompanying the de- ation and motor excitement.

terminal dementia, characterized by stupidity. acute dementia is confusional insanity, lacking in nt of mania or the depression of melancholia.



An important group, where pathology is well known (inflammation of the cortex), is general paresis, characterized by exaltation, with delusions of grandeur and a progressive paresis. It ends in dementia, and is incurable at all stages.

Paranoia is a form of insanity that is of importance, because its victims are frequently dangerous to others, sometimes violently homicidal. Its chief, if not only symptom, is delusions of persecution. Otherwise the intellect is but little affected, and the emotions primarily normal.

The insanity of epilepsy is easily recognized from the history of convulsions; it is characterized by great violence, which is often unconscious. Sometimes in epilepsy, the convulsions are absent, being replaced by outbreaks of mania.

In one group the general practitioner is called on to treat quite frequently, may be placed the toxic insanities of morphinism, cocaineism, and puerperal insanity. These, as a rule, are curable, and can often be successfully treated at home.

To be able to recognize paranoia and general paresis, is of great importance to the general practitioner. The paranoiac is often, while apparently sane, meditating dire vengeance against people, who he imagines intend to do him harm. The physician should be competent to detect this form of mental disease, and sound the note of warning. The general paretic with his optimism, often wastes his estate before he is known to be insane.

The study of insanity has a peculiar interest at this time, for the reason that it is undoubtedly increasing.

#### THE INCREASE OF INSANITY.

Statistics from both Europe and America show that in recent years there has been an increase in the number of insane out of all proportion to the growth of the general population.

The number of insane under official cognizance in Great Britain and Ireland in the year of 1862 was 55,525, and the population at large 29,197,000 in round numbers. In 1891, the number of insane had increased to 117,336 and the general population was 38,133,000, which is to say that there were nearly three times as many insane at the end of twenty-nine years as there were at the beginning of that period, while the general population

id increased but 30 per cent. That I may not weary you with too many figures, I will ask you to take my statement on trust that, there has been no diminution in the absolute and, relative increase of insanity in Great Britain and Ireland in the twelve years that have passed since 1891. The per-centage having risen until there is now about one insane person to every three hundred inhabitants. In Ireland more recent statistics show that the number of insane has increased, while the general population is actually diminished.

Turning to our own country, we find in the populous centers at the picture is equally dark. In the Southern states, the ratio of insane to the general population is less than in the more populous North. We have fewer large cities where the factors of insanity abound. In a rural community, life is healthier and more tranquil, and, the ability to earn a comfortable income, is more certain than in cities. Then too, we have a small foreign population which is notoriously prone to the development of this disease. In New York, the foreign born population is only twenty-five per cent of the whole, while fifty per cent of the inmates of the State Insane Hospitals are of foreign birth.

In the Federal census of 1900, the enumeration of the defective classes, has not yet been published, so that information from that source is not available. Tennessee has nineteen hundred insane of public charge, and, probably twenty per cent more who are cared for by their relatives. From statistics of my own, in the large rural population of Eastern Tennessee, there is one insane man or woman for every seven hundred of the total inhabitants.

New York had under State care in 1900, 22,088 insane, with yearly increase of seven hundred, as shown by the report of the Commission of Lunacy for that year — a ratio of approximately one to every three hundred of the population. The cost of maintenance alone of this army of defectives, was for the year 1900, \$3,644,520.00. The eminent Publicist, Mr. F. B. Sanborn, prepared for the National Conference of Charities and Corrections, which met at Atlanta last May, a report on the insanity of New England. Mr. Sanborn's figures show beyond a doubt, that insanity there is increasing beyond the natural increase of population. "On October 1, 1897, there were in Massachu-

setts in public institutions, or boarded out in private families and alms-houses, 7285 patients. On Oct. 1, 1892, there were 9121; percentage of increase for five years 25.2, annually 5 per cent. Not to go farther with figures, I would state that, in all New England, there is one insane person in every 307 inhabitants. The criticism has been made of figures, such as these, that the increase is apparent rather than real; that as accommodations for the insane are multiplied, they are brought forward to fill them. Doubtless to some extent this is true, but when due allowance is made for this consideration, the fact that over a large portion of our country, the ratio of insane to the general population is approximately as one to three hundred, is proof of a rapid multiplication of the insane. No such condition obtained fifty years ago.

#### CAUSES OF THE INSANITY INCREASE.

Among the first may be mentioned the great intellectual activity of the Nineteenth Century, especially the latter half of it, and the revolutionary changes that it wrought in the lives of people living where these effects were operated. The annals of no previous period of the world's history will bear comparison with the century that has just passed, for intellectual activity of every kind, and in it man seems to have reached the flood-tide of his achievements. Great strides have been made in all the sciences, especially in medicine, and as a result, the multiplication of specialties. But the most striking and dramatic effects have been wrought by the inventors. The Watts, the Stephensons, Fultons, and Edisons—these, availing themselves of the discoveries of the patient investigators of the laws of Nature, and sometimes adding to them by discoveries of their own, by bending to their will the forces of Nature, through the medium of machinery, have multiplied the working power of human hands an hundred-fold. As a result of all this, a complete change was wrought in the lives of the people; their methods of gaining a subsistence were taken from them. They were compelled to turn to new employments, to face problems that harrassed and perplexed them, and to earn their bread by methods exhausting to the nervous system. Under

uch conditions, individuals of frail constitution and nervous diseases, break down, while only the strong can endure themselves to such environment.

I have already alluded to the degenerating effect of urban life on the human frame, or rather the degenerating effect of that life which is led in cities, for one may be healthy in them with a rural life. It is significant that the increase in insanity in the last fifty years has been synchronous with an unprecedented increase in the urban population. This is especially true of Europe. The increase of population has been confined almost wholly to the cities, for the sufficient reason that the country had already been so thoroughly cultivated that no one could live by cultivating the soil. The establishment of manufactures and the growth of commerce, took up the surplus population of the country. And it is there, in the heart of civilization, among the most enlightened peoples of the earth, is to be found the greatest ratio of insane to the general population. The causes that bring about insanity in cities, are not far to seek. Among people of wealth, the enfeebling effect of luxurious living, with late hours and dissipation, a strenuous business life, the waste to get rich by speculation, exhaust the nerve centers and result in insanity. Men who work for moderate salaries lead also an exhausting life. The army of book-keepers and clerks toil indoors during the hours of daylight, and in the evening instead, like the farmers of going to bed for nine hours of repose, they seek amusement in ways that are more or less exhausting to the vitality. The condition of the laboring classes is not more favorable to the building up of, and the preservation of a sound mind and a sound body. Many of them live in crowded apartments situated in unwholesome districts, and the hours of labor spent in the impure air of the factory, shut out from health-giving breezes and sunshine. Strikes and lockouts interrupt the flow of their lives, and cut off the sources of their daily sustenance. Accompanying these interruptions of labor, too often the pitched battles in the streets with the police. With them the temptation to encroach upon the hours of repose by dissipation is not wanting. With such depressing conditions operating from generation to generation, what wonder is it that insanity numbers its victims by increasing thousands.

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What part should the general practitioner take in stemming the tide of this evil? It divides itself into two categories, both having for their end the prevention rather than the treatment of the disease. From the nature of the malady it can seldom be successfully treated in private practice, but the family physician can do more than any one towards diminishing one of the most serious evils of the times in which we live, by giving good counsel to those, who by inheritance are liable to this disease, and by using his influence to secure, by legislation, its suppression.

An hereditary predisposition is found in eighty per cent of the cases of insanity. Without this basis, intemperance, financial distress, domestic grief, the abuse of narcotics and exhausting labor will not bring on mental collapse, at least not in one generation. Without doubt, prolonged violation of hygienic laws, will, in time effect racial degeneration.

"The fathers eat sour grapes and the childrens teeth are set on edge." But these exciting causes are potent to send to the hospitals for the insane those less richly endowed, and the general practitioner should point out to them the means of escaping the evils that menace them. There are many people of high intelligence who bear in their blood the latent taint of mental disease, and who are aware of the peril in which they stand, and take to heart the counsel of the wise physician whose words, when duly followed, have power to save. To such he may say, with confidence, "Be of good cheer," not all who are exposed to danger suffer calamity, and if you obey the laws of health, you may live to old age, and escape the curse of your inheritance. He should tell such clients that insanity is a disease of the brain, a material organ, and from its normal action healthy feelings flow, equally removed from the excitement of mania and the depression of melancholia; that in it, neither hallucination nor delusion can arise, for it mirrors truly the report the senses bring it of the phenomena of the world external to itself; that the possessor of such a brain is not carried away by sudden gusts of feeling, but knows how to subordinate clamoring passions to the dictation of reason, that in a word normal brain function means sanity, while perverted brain action is the reverse. Having disabused his mind of metaphysical conceptions of soul and mind, as distinct from

matter, show him that his brain is in direct connection with all parts of the body, and that, therefore, the highest degree of general health is the best guarantee of healthy brain function.

As for moral hygiene, one prone to brain disease, should so order his life, so far as he may, that stress and worry and feverish excitement may not be his daily portion. He should not enter on the mad race for riches, but having chosen a business that will bring him food and raiment, let him be therewith content. In view of the hereditary nature of his diathesis he should be advised not to marry. Such people are sometimes advised to marry into healthy families with the idea of diluting the evil and thus diminishing the chances of defective offspring. I never give such advice; it spoils good stock of which the world has all too little, and besides is manifestly unjust to the other contracting party. In his capacity of public advisor, in matters of public health, the General Practitioner finds his field of greatest usefulness in the management of insanity, and one in which he is accustomed to labor without fee or personal reward. All that tends to promote the general health of the people is prophylactic of insanity, and I need say nothing on that head, but I wish in conclusion to call your attention to a question in state medicine that is as yet *sub judice*, namely the regulation by law of the right of those suffering from, or strongly predisposed to hereditary disease, to contract marriages.

Lest I be thought chimerical in advocating this, I will say that I have been charged with holding fanatical views on the subject of state interference by my professional brethren, because I do not believe in forcible vaccination and was opposed to a medical practice act that goes further in the restriction of the practice of medicine than to deprive the unlicensed practitioner from collecting his fees by law. Notwithstanding my belief that the progress of the race is best promoted by leaving to individual effort the greatest possible liberty, I think it high time that some restraint be placed on the reckless propagation by criminals of their kind to prey on society, and the multiplication of the insane by marriage when all but an insignificant number of them sooner or later, become a public charge. We should be careful not to go too far in advance of public opinion in advocating such legislation, nor to bring too many subjects within its provisions.

Your President in his admirable address last night, called your attention to the enormous financial loss caused by the criminal classes. His adversion is timely and should set us to thinking, at least, on this subject. Other states have laws forbidding the marriage of the insane and of epileptics, and why should not Tennessee? The criticism that they are not general and that those forbidden to marry in one state can go into another, is not valid. Nothing can be effected unless a beginning is made, and if nothing more is done by the passage of such a law in Tennessee than to call attention to the evil it is intended to suppress, much will have been accomplished.

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### A PLEA FOR CONSERVATIVE SURGERY OF THE HAND.\*

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BY PAUL F. EVE, M. D., OF NASHVILLE, TENN.

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In presenting this subject I am fully aware that I have nothing new to bring before the Association; yet its great importance, the unnecessary amputations and the many deformities of the hand, have encouraged me to tax your patience for a short time.

When we view the immensity of space and see within it worlds upon worlds, held by the mysterious force of gravity, ever obeying the mandates of law and order, we are compelled to bow and own that He who made them, is an infinite being and one whom we worship as God. It seems to me that in all the creative power of God, there is nothing so marvelous or so intricate in mechanism as the human hand; and I speak with all reverence when I say that infinite capacity was taxed almost to its utmost *in making of the hand*.

Man, who when created, was made a little lower than the angels, has imitated many of the mechanical creations of God, but when called upon to supply the deficiency of a hand, has utterly failed; his ingenuity by no means being adequate for the occasion. No wonder in the Divine Writing, we hear men

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\*Read at Annual Meeting of the Tennessee State Medical Association, April 15, 1904.

old, moved by inspiration, exclaiming that the heavens are the handiwork of God; and as if to present the most wonderful of all creative parts to draw humanity to a better life, they are often heard to say, "The hand of the Lord is stretched out all the day long."

Early in my professional career, I was impressed with the wonderful mechanism of the hand, and as I dissected its various parts or supervised others in their dissection of it, I was lost in amazement and wonder at the intricacies and the combination of the various parts which enter into its formation as a whole.

Fully convinced of the importance of an adequate study of the anatomy of the hand and the useful part which it plays in obtaining daily bread for the sustenance, not only of our own body, but those dependent upon us, we should insist upon a much more careful diagnosis of the diseases and surgical affections, in order that the same might receive prompt attention, thus not only saving portions, but often the whole of the hand.

It is not my purpose to enter minutely into the various diseases which lead up to surgical operations on the hand, as this paper would not only be too long but unnecessarily weary the patience of this Society; but I do desire, in as cursory manner as possible, to call attention to the more important conditions demanding treatment.

Before proceeding further, it is well to call your notice to some of the anatomical peculiarities of the hand. "The muscles of the hand are subdivided into three groups: those of the thumb, which occupy the radial side and produce the thenar eminence; those of the little finger, which occupy the ulna side and give rise to the hypothenar eminence; and lastly, those of the middle of the palm and within the interosseous spaces. There are also two synovial membranes, which enclose all the tendons as they pass beneath the annular ligament. One for the flexor sublimis and profundus digitorum; the other for the flexor longus pollicis. These extend into the fore-arm for about an inch above the annular ligament and then downward about one half way along the metacarpal bones where they terminate in a blind diverticulum around each pair of tendons with the exception of



that of the thumb and of the little finger. In these two digits, the diverticulum is continued on and communicating with the synovial sheath of the tendons of the fingers, the synovial sheath of the tendons begins as a blind pouch without communicating with the large synovial sac." I also desire to call attention to the deep palmar fascia which forms a common sheath investing the muscles of the hand. This fascia is divided into a central and two lateral portions; the central portion occupying the middle of the palm is triangular in shape and binds down the tendons, while it also protects the vessels and nerves. It is attached above to the lower margin of the annular ligament receiving the expanded tendon of the palmaris longus muscle, while below it expands and divides into four slits for the four fingers. The lateral portions of the palmar fascia are thin, covering on the radial side the muscle of the ball of the thumb and on the ulnar side the muscle of the little finger and is continuous with the dorsal fascia. It should also be remembered that not only has the hand its own separate muscles, but it receives tendons from a number of the muscles of the fore-arm. All of these points must be carefully studied and taken into consideration as a guide for the proper management and treatment of these surgical affections.

The group of injuries resulting from rheumatism, gout, tuberculosis, and syphilis, and which are so frequently followed by either an acute or chronic synovitis or even an arthritis, call for prompt treatment that must be conducted upon rational principles, or they will lead not only to great deformities, but to a complete loss of the function of the hand.

The various means of diagnosis of these diseases are familiar, I therefore only propose to offer some suggestions in treatment. It is now an axiom with all surgeons, and I am glad to state this is being taught in medical colleges, viz., that the only adequate and proper means to carry out the great fundamental principles in the treatment of general inflammation of the hand is to enjoin rest with proper position, this being done by placing the hand upon a splint, thus preventing any movement. Every orthodox medical treatment should be fully tried before resource should be had to surgical interference. Long before

nature has thrown out its great signs or red light signals, as I am pleased to call them, informing the surgeon that great devastation has already begun, not only in the soft, but in the bony structures, viz., the establishment of fistulous openings, the contents of which are frequently gritty upon pressure between the fingers, treatment should be instituted so as to prevent great suppuration and loss of tissue.

In case of tubercular thecitis, the most heroic of all surgical methods should be adopted, especially when suppurative tenosynovitis involves the thumb or little finger. A free incision should be made in the suppurating area, the sheath of the tendon laid wide open and all the surfaces curetted. If this plan is not adopted, the surgeon will soon wake up to the realization that not only will the tendons become involved by adhesions, but the bony structures suffer themselves, and that the hope of saving the hand is very meager, and even if saved, will at best be a stiff and useless member.

In the treatment of the various wounds of the hand, every attention should be paid to thorough cleansing and drainage, and no wound should be thought too trivial to receive proper attention. For some of the most trivial wounds we have had the most disastrous results. If it should be a punctured wound, it calls for a thorough opening to the bottom, the wound then being packed until it heals from the deepest point. If the wound involves either the superficial or deep palmer arch, I do not believe it wise surgery simply to control the hemorrhage by a compress and bandage, as I have had under my observation not a few cases where aneurysms have resulted and where an operation was necessary for the relief of the blood tumor. I would therefore advise that an incision sufficiently large should be made for the ligation of the bleeding vessels and after these are secured the wound sutured. Too many cases of unsightly and deformed hands have resulted from burns for me not to call special attention to the treatment of such conditions. It is as I believe, a very erroneous impression among some members of our profession, that in the vast majority of burns we have a contraction of the tendons of the fingers, while the truth is, that in only a few cases and those of very deep burns, are these

tendons involved. In the vast majority of cases, the burn produces simply a contraction of the palmar fascia, and myotomy for correcting these deformities can be easily and readily made. In the treatment of recent burns, after having combated shock and relieving pain, the hand should be placed upon a well padded splint, and if any contractions begin to occur, gentle manipulation frequently carried on from day to day should be instituted, until the deformity is entirely corrected. It is wonderful how kindly these cases heal under such treatment. When contractions do occur, it is the duty of every surgeon to perform a plastic operation and relieve the condition. In any wound involving the cutting or tearing of a tendon, the tendon if possible should be united at once, and if too short it should be lengthened out in the manner proposed by Anderson.

In necrosis of the carpal or metacarpal bones, an operation for the removal of these diseased structures should be done. I have been very much gratified in many of these cases which have come under my treatment, by the limited amount of surgery which was needed, such as only requiring the removal of a portion of a carpal or metacarpal bone, or perhaps the loss of only one such bone. Even when disease attacks a number of these bones at once, I have had good results following the removal of all the carpal bones; and in some cases where I was compelled to remove the first row of the carpal bones, together with the lower end of the radius and ulna, good results have followed. In this operation great pains should be taken in preserving every tendon and nerve. While such an individual can not be said to have an excellent hand, yet it is far superior to any artificial device that as yet has been manufactured, we can not but congratulate ourselves upon the result.

I should not neglect to call attention to injuries of the fore-arm, which lead to so many deformities of the hand, such as wounds involving the cutting of nerves or of muscles or more especially those of compound fractures of one or both bones of the fore-arm. Many a hand has been rendered partially or wholly useless by the improper treatment of such injuries. When nerves or muscles are cut or lacerated they should be united at once, and when portions of them are destroyed, they should be lengthened out and then united.

We have now at our command an invaluable agent in the treatment of fractures in the shape of the X-Ray machine, and it is practical and possible for almost anyone to see that the bones are placed in proper apposition so that the treatment may result in a complete recovery and a useful member. It is my belief that many hands have been wantonly amputated which with a little care and painstaking, could have been either partially or completely saved; and it with the deepest regret and sorrow, when brought face to face with the necessity of amputating the hand, that I gain my consent to such an operation.

I remember some time ago I had under treatment a switchman, who received a severe crushing of his hand. It was caught between the bumpers of moving cars, and as I looked upon this mangled hand, there was but one thought in my mind, that was an immediate amputation. Before placing my patient under the influence of ether, he begged and plead with me that I should save every portion of his hand that was possible, remarking as he looked up to me with tearful eyes, "Doctor, remember my daily bread depends upon the use of these hands." I promised him and resolved at the same time to fulfill that promise, and that if I found any portion of this mangled extremity could be saved, I would attempt to do it.

The little finger, the only one which gave any promise of saving, was broken in its first and second phalanx, its metacarpal bone not being injured. I was also enabled to save one half of the metacarpal bone of the ring finger and all the carpal bones save the trapezium and trapezoid. There was scarcely enough integument for a flap, but I determined to give him this chance, the wound finally healing by granulation. The result met my most sanguine expectation, and to-day this switchman, with his little finger on the right hand, is doing marvelous things, and there is scarcely any work that he is not able to perform.

This case paved the way for many other cases, and I have been as conscientious and conservative as possible in the treatment of such injuries.

I make the appeal therefore, Gentlemen of the Association, for the preservation of the hand, and as you may think and ponder upon this subject, if I have but been enabled to interest you

to such an extent as to place you upon your guard in the treatment of this wonderful piece of mechanism, I have accomplished my purpose.

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### CHRONIC DYSENTERY — A PROTEST.\*

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BY A. B. COOKE, M. D., OF NASHVILLE, TENN.

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Probably no disease has occupied a more conspicuous place in medical literature than dysentery, and it may be truly said that until a very few years ago little difference of opinion existed as to its etiology and pathology. Formerly it was believed to be a specific constitutional disease due to causes as definite and invariable as those of tuberculosis and typhoid fever. To-day authorities are teaching that dysentery, whether sporadic or epidemic, is primarily a local infection of the large intestine, and that the site of the infection is most frequently found in the distal half of the colon, including the sigmoid and rectum: (Flexner, Zeigler, Cruikshank, *et als*) and further, that the constitutional element of the disease is purely secondary, due to absorption of septic products from the infected area after ulceration occurs. While the cause is admitted to be bacterial, according to Flexner, the ameba dysenteriae has not been proved to be the specific factor even in the production of tropical dysentery.

For present purposes the fact which most concerns us with reference to the acute affection is that the site of the infection is invariably the large bowel. While the distal portion of the ileum and the cecum may exceptionally be involved, the distal portion of the colon and the rectum as a rule are implicated. A moment's reflection will show that this must be so; for even though the primary focus may be in the ascending or transverse colon, every part of the bowel below is of necessity continually exposed to the contaminating discharges.

In the light of these facts it may be said in passing that no plan of treating acute dysentery can be considered a rational one which does not include measures applied directly to the parts affected in the most direct way possible, *i. e.*, through the rectum.

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\* Read at Annual Meeting of the Tennessee State Medical Association, April 15, 1904.

Now what is chronic dysentery? Let the writer's position be clearly defined: correctly speaking, he believes that the disease, if there be such a disease, is very rarely encountered in this portion of the country. Yet, if all the cases which are so designated were in reality chronic dysentery, it might be truly considered the most frequent and widespread of all diseases of the intestinal tract.

If the data were sufficient to form a reliable guide, the study of this subject would be facilitated by approaching it from two standpoints, namely: first, what proportion of cases of acute dysentery is followed by the so-called chronic form? ; and, second, what proportion of cases of so-called dysentery give clear histories of acute attacks immediately preceding?

With reference to the first question, statistics can not be appealed to for an answer. Most authorities state that "sometimes" or "in a certain proportion of cases" the acute disease lingers on in the chronic form; but not one of them undertakes to define what "sometimes" and "in a certain proportion of cases" mean, and not one of them attempts to discuss the question of pathology in a sufficiently intelligible and scientific manner to establish the vital point as to the identity of the two forms.

My own experience in the treatment of chronic dysentery has been very limited, but the fact is stated for what it may be worth, that I have personally never known a case to assume the chronic type. It is conceivable and conceded that such a termination is possible. But let us not fall into error on this point. To establish the fact of chronicity with respect to any particular disease requires at the present time that, though the clinical picture may present variations, its identity, etiologic and pathologic, with the acute disease be scientifically proved. The weak point in the argument of those who believe in the frequency of chronic dysentery is that they have not succeeded in establishing such identity. Because a patient presents himself some days, or weeks, or months, subsequent to an attack of acute dysentery complaining of more or less frequent blood-stained discharges from the bowel, the diagnosis of "chronic dysentery" is promptly made, and usually without even the suggestion of an examination. With respect to no other class of diseases is our profession so

habitually and flagrantly lax in the matter of diagnosis. An accumulation of fluid in the pleural cavity due to an attack of acute pleurisy is not diagnosed "chronic pleurisy." Suppurative otitis media following an inflammatory disease of the throat is not called "chronic pharyngitis." Nor is fecal fistula resulting from an operation for appendicitis termed "chronic appendicectomy." These are recognized as complications or sequellæ, and no such absurdities of nomenclature are attempted. Yet with reference to the affection under discussion exactly this absurdity is calmly and seriously perpetrated every day in the week. Because a patient at some time, near or remote, in his past life has been the victim of an attack of acute dysentery he is forever after debarred from what may be termed the rectal prerogatives of the ordinary individual—he can never possibly have a simple ulceration of his rectum, nor an acute procto-colitis, nor indeed any other trouble attended by blood-stained discharges except "chronic dysentery."

The truth is that every case of acute dysentery is attended by a greater or less inflammatory involvement of the rectal mucosa due to the irritating discharges from above, hence the tormina and tenesmus which are such distressing features of the disease. No element of specificity is necessary to account for this. And when the inflammatory process results in loss of tissue, as is doubtless often the case, the ulceration so produced may or may not be chronic, but it certainly can not be correctly regarded as other than a sequel of the original disease and should not be designated by a name at once inaccurate and misleading.

Considering the subject from the viewpoint suggested by the second question—what proportion of cases of so-called chronic dysentery give clear histories of acute attacks immediately preceding?—a more definite answer is possible. In the past eight years I have had under my care between eighty and ninety cases which were so diagnosed either by the patients themselves or by the physicians who referred them. In each case I have invariably inquired closely as to a history of acute dysentery, and out of the rather considerable number of cases mentioned my record-book shows that such history was obtained less than a dozen times.



It would be interesting to tabulate the entire series so as to show the wide diversity of pathologic conditions encountered. Here it must suffice to say that proctitis, procto-colitis, ulceration of the rectum (simple, tubercular, syphilitic, and malignant), stricture (malignant and non-malignant), polypi, and even internal hemorrhoids, were the different conditions met with in one or more instances. It is worthy of remark also that none of the several cases which gave a history of a previous attack of acute dysentery presented a pathology or clinical phenomena in any sense peculiar or distinctive. The one feature possessed in common by all cases was blood in the discharges, but this one feature had been seized upon and for diagnostic purposes evidently regarded all-sufficient.

During the past week I was consulted by two patients, one from an adjacent county in Tennessee, the other from Alabama. Each patient was accompanied by his physician who in both instances assured me in the most matter-of-fact tone that the trouble was "chronic dysentery," and could not understand why their large doses of bismuth, astringents, etc., had failed to reach the case. The first patient gave a history of an attack of acute dysentery about a year ago and dated the beginning of his trouble from that time; the second had never had an acute illness of any kind. Upon examination the first case proved to be one of diffuse follicular ulceration of the rectum complicated by a general inflammatory involvement of the colon and sigmoid of chronic type. This patient was having many discharges of bloody mucus in the twenty-four hours and had lost sixty pounds in weight during the past year.

The second case presented no local pathology except a mild catarrhal procto-colitis. The "chronic dysentery" in this case was accounted for by the fact that several times each year during the past ten years, the patient had had attacks of indigestion accompanied by diarrhea, and the passage for several days following of blood-stained mucus.

I merely refer to these two recent cases as fair illustrations of the abuse of the term "chronic dysentery."

Some one may inquire at this point. "What is all the row about? What difference does it make by what name the trouble



is called?" I answer, the row is about something more than a mere abstraction, and the difference it makes in many instances involves the issue of life and death. If the position I hold on the subject is correct, the term "chronic dysentery" in the great majority of cases is a misnomer; whether the position be correct or not, the name is worse than misleading. The time-honored teachings in regard to the treatment of acute dysentery uniformly endorse medication by mouth, and the same idea obtains almost as uniformly as to the management of the so-called chronic form. The very name, dysentery, which the patient is usually ready to suggest for his malady, seems capable only of the routine therapeutic translation, bismuth, opiates, and astringents. It would utterly astonish the members of this learned body if I should give the treatment which I have known to be employed in some of these cases. Heretofore I have expressed the conviction and I make bold to reiterate it in this connection, that in this fair Southland of ours many a sufferer has found everlasting peace as the result of a physician's misguided efforts not to mention others who exist in living death, slaves to the opium habit.

My purpose in this brief paper, Mr. President and gentlemen, has been simply to lay before you my personal views as to the real nature of this so-called "chronic dysentery," and to beg that the term be dropped from our vocabulary. To summarize, the points I would especially emphasize are:—

First, that almost without exception the condition so named is purely local.

Second, that the term "chronic dysentery" as ordinarily employed does not and can not refer to a definite pathologic entity, but rather covers a wide variety of local diseases in no way related to dysentery.

Third, that a chronic discharge from the bowel unattended by the well-recognized symptoms of a general systemic disease process, always indicates a lesion of the rectum, sigmoid, or colon; and

Fourth, that the idea of a necessary relation between bloody discharges and chronic dysentery is based upon a false assumption and should be both abandoned and forgotten.

In order that we may know the truth with reference to these

cases, the one thing needful is that every patient who consults us for such trouble be, without exception, subjected to careful physical examination. In the name of humanity and for the honor of the great profession to which we belong, let us not be content with conjecture where we may have knowledge,—with failure where we should have success.

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## *Abstracts.*

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### THE TREATMENT OF SEROUS EFFUSIONS.\*

The author describes what is evidently a new method of treating serous effusions. The idea occurred to him to inject one fluidrachm of Adrenalin Chloride Solution into the pleural sac, in a case of abdominal cancer extending to the pleura, after the aspiration of a large quantity of bloody serum, the object of the injection being to lessen the secretion. There was no further secretion, consequently no further tapping and the patient spent the remainder of her life in perfect comfort so far as her chest was concerned.

This treatment was extended to cases of ascites due to hepatic cirrhosis in which marked results were not expected. However, the quantity of the Adrenalin Solution used varying from two to three fluidrachms.

In a case of pericarditis with effusion in a lad, nineteen fluid-ounces of serum was withdrawn from the pericardium, but a reaccumulation rapidly followed. The patient's condition becoming critical, the paracentesis was repeated, twenty ounces of fluid being withdrawn with immediate improvement in the quality of the pulse. Forty minims of Solution Adrenalin Chloride, 1-1000, was injected into the pericardium. The pulse at the wrist disappeared, the boy became of an ashy leaden hue and had an anxious expression. Immediately nitroglycerin and atropin were administered and the boy quickly rallied. No fur-

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\* Abstract of a Clinical Lecture delivered at the Liverpool Royal Infirmary, by James Barr, M. D., F. R. C. P. (*The British Medical Journal*, March 19, 1904.)

ther tapping was required. The same patient had a subsequent attack of left pleurisy with effusion. Ten fluid-ounces of serum was withdrawn from the chest and one fluidrachm of Adrenalin Chloride Solution was injected. There was no reaccumulation.

In a case of tuberculous peritonitis and ascites two hundred fluid-ounces of serum was withdrawn and two fluidrachms of Solution Adrenalin Chloride introduced into the peritoneal cavity, with four pints of aseptic air (to prevent adhesions). Thirteen days later 237 fluid-ounces of serum was withdrawn and two fluidrachms of Adrenalin Chloride Solution and two pints of air were injected. Upon a third occasion, eleven days later, 196 fluid-ounces of serum was obtained by tapping, and three fluidrachms of Adrenalin Chloride Solution and four pints of sterile air were injected. No reaccumulation of fluid occurred.

A female child of seven years was the next patient. One pint of fluid was withdrawn from her pleural cavity and one fluidrachm of Adrenalin Chloride Solution and half a pint of sterile air were injected. Though it was highly probable that the pleurisy was tuberculous there was no reaccumulation of fluid and the patient recovered.

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### CACTINA IN FUNCTIONAL DISEASES OF THE HEART. \*

After referring to all recognized heart stimulants, Dr. Hatch concludes: The last in the list of cardiac stimulants, but by no means the least, is cactina. This drug is the proximate principle of the *Cereus Grandiflora* (night blooming cereus), and belongs to the natural order of Cactaceæ, a plant indigenous to tropical America. This active principle was most successfully isolated by a pharmaceutical chemist of St. Louis, Frederick W. Sultan, who obtained it from the flowers and stems of the Mexican variety, which yields a greater and more constant quantity than any other species. This drug is non-irritant, and can be applied to the conjunctiva in a ten per cent. solution without producing any noticeable effect. Therapeutic doses cause a rise in the ar-

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\* Abstract from an article in the *Medical Examiner and Practitioner*, by John L. Hatch, B. S., M. D., New York.

terial pressure and increase in the pulse rate, whereas toxic doses cause first, acceleration of the pulse and a rise in arterial pressure that is followed by a drop in the pressure and a diminution in the rate of the pulse. The pulsations become irregular and spasmodic, and the heart is finally arrested in systole.

A fair conclusion is, that the drug produces these effects chiefly by direct stimulation of the intra-cardiac ganglion.

From this we may summarize that the action of the cactina in therapeutic doses is to increase the musculo-motor energy of the heart, elevate the arterial tension with a corresponding increase in the height and force of the pulse wave, and to elevate the general nervous tone by stimulating the motor centres in the cord.

Cactina is indicated then whenever we need a powerful cardiac tonic stimulant.

Its greatest value has been shown in functional disturbances of the heart, such as simple dilatation and cardio musculo-atony, in which there are no organic lesions.

It has a great advantage over digitalis in that it can be administered continually without producing gastric irritation and without fear from cumulative action.

It is of use also in organic diseases of the heart, save in one instance, viz., mitral stenosis, where digitalis is to be preferred because it prolongs the diastolic period, thus giving the ventricle time and power to empty itself.

The dose of cactina with which the best results have been obtained is 1-100 of a grain (in the form of Cactina Pillets), repeated at frequent intervals. The continued use reduces and regulates the pulse by giving strength and tone to the heart's action.

In several cases of functional disturbances of the heart, particularly tobacco heart, in which I have prescribed cactina, I have been able to reduce the pulse rate within a few hours, and by the withdrawal of the narcotic and continued use of the drug bring the patient to a normal condition.

My experience with cactina has been such that I put more faith in it for functional disturbances than any other remedy that I have tried.

## *Clinical Reports.*

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### CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

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STATED MEETING HELD APRIL 4, 1904.

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The President, Dr. James Hawley Burtenshaw, in the Chair.

#### SYPHILITIC PERIOSTITIS.

Dr. W. R. Townsend presented a patient, aged 26 years, with a syphilitic condition of the wrist. Five years ago a diagnosis of tuberculosis of the wrist was made, and a partial excision performed, which resulted in a movable joint. Two years ago a tapering swelling was noticed at the phalangeal joints, attaining its greatest diameter at the articular surfaces. When first seen by the speaker, three weeks ago, he had X-ray photographs of the hand taken, and by this means established the diagnosis of syphilitic periostitis, with joint inflammation. This condition undoubtedly existed when the excision was done for the relief of the supposed tubercular disease. It was an excellent illustration of the value of the X-ray in diagnosis, and especially in differential diagnosis. Radiographs of a tubercular wrist were also shown, in order to bring out clearly the differences between a syphilitic and a tubercular process. The patient has been on antisyphilitic treatment for three weeks, and in that time the pain has decreased, motion had increased, and her feet, which were affected by a similar pathological condition, were much improved, making walking much easier. The speaker also showed a radiograph in which the bones of the ankle were affected by syphilis, and, by way of comparison, one of a foot in which the bone was normal, to illustrate the changes which the bone and surrounding tissues undergo in syphilitic periostitis.

#### MYOSITIS OSSIFICANS.

This case was also reported by Dr. Townsend. He said that this disease, in which the muscles undergo bony changes, is very

rare. The most common cause is traumatism, and a Japanese surgeon has reported several cases since the beginning of the Russo-Japanese War, in cavalry officers, whose adductor muscles have been damaged and this condition has resulted. When there is no history of traumatism, there is no clue as to why certain muscles should be affected. In the case reported, such a large mass of muscle was infiltrated with bone that there was no motion at either knee or ankle. On one side the femur and muscles were normal, which could be distinctly seen by the X-Ray apparatus; on the opposite side, extending from the pelvis along the track of the adductor muscles there was a bony deposit almost similar to the bone in the shaft of the femur.

The second radiograph showed the process extending into the lower leg. The flexed bone could be seen, and extending to one side a solid mass of infiltrated bony muscle. In a short time all the muscle on that side of the limb would be affected, and there would be a solid bony mass in addition to the fibula itself. The muscular motions, of course, will be lost, and the patient may have to lose the lower extremity. The prognosis in these cases is very bad and treatment is unsatisfactory. Such cases are rare when, as in the present case, there is no history of traumatism.

#### HYSTERICAL COUGH.

Dr. G. B. McAuliffe presented a young woman who was suffering from paroxysms of hysterical coughing which resembled in sound the barking of a dog. About one year ago she began to cough, and has coughed almost uninterruptedly ever since. Examination showed no local lesion, and the cough seemed to be purely laryngeal. Nothing abnormal is to be seen in the larynx except a slight redness over the arytenoids. Extralaryngeal applications of electricity afford relief, but internal medication has been of no avail. The application of adrenalin by means of a spray gives relief for twelve or fourteen hours, when another paroxysm comes on. This, however, is merely a symptomatic treatment of the cough.

Dr. D. J. McDonald said that he had seen the patient about a year ago, and that he had applied electricity each day, first using the high-tension and later the galvanic current. When

first seen by him she had presented every symptom of hydrophobia, barking and foaming at the mouth, but was able to walk about. Under treatment her condition improved so that the attacks occurred only monthly, and later only once in two months. She was also given adrenalin and arsenic internally.

#### FRACTURE OF THE BASE OF THE SKULL.

Dr. John A. Bodine showed a boy who had been operated on by him at St. John's Hospital for fracture of the vault involving the base of the skull. The patient, while coasting down a long hill, having acquired a terrific impetus, crashed into a wagon, his head striking the hub of a wheel. The temporo-parietal region of the skull was not unlike an egg-shell crushed in. He was taken to the hospital in a condition of profound shock, and it was thought unwise to resort to any operative procedure to relieve the brain-pressure or to stimulate with salt solution for fear of inaugurating intracranial bleeding. This condition of stupor lasted three days and three nights when his condition began to improve. With practically no anesthesia the larger portion of the parietal bone was removed. The fracture was compound and extended through the temporal bone and into the base, and was again compound in the vault of the pharynx. He had bled profusely into his stomach, which blood was vomited. When all of the depressed fragments of bone had been removed the boy's condition improved steadily until he was out of danger. Some time during the second week after the injury right sided facial paralysis, paralysis of the right external rectus muscle of the eye, and loss of taste in the right side of the tongue was noted. In addition, there was asymmetry of the soft palate during phonation. The study of the anatomy of the parts thus involved demonstrated clearly the line of fracture at the base of the skull. With facial paralysis, with asymmetry of the soft palate and loss of taste on the right side, the fracture must have included the bony parts traversed by the facial nerve between the geniculate ganglia and the origin of the chordæ tympani nerve. Furthermore, as there was paralysis of the external rectus muscle of the eye, without involvement of any of the nerves that lie in juxtaposition with the external rectus in the cavernous



inus, the line of fracture must have been near the posterior clinoid process of the sphenoid bone. It does not seem reasonable to expect that the ophthalmic nerve would have escaped, had the line of fracture been anterior to these processes. The fact that paralysis came on two weeks after the receipt of injury would indicate that it was due to an inflammatory process of the nerves, making the prognosis as to the ultimate recovery of these paralyzed muscles better than if the paralysis had been coincident with the injury.

#### DEFORMITY FOLLOWING FRACTURE OF THE CONDYLE OF THE HUMERUS.

Dr. Bodine also showed a case of deformity following fracture of the external condyle of the humerus. When the patient was seen the arm was swollen, and a most careful examination under anæsthesia demonstrated nothing more than that it was a fracture of the external condyle involving the joint. It was treated in a position of acute flexion, the hand midway between pronation and supination. When healing had occurred and the arm was taken down, the existing deformity over the external condyle was found. Nearly a full range of motion of the joint has been secured. Since this patient's injury the speaker has seen two other fractures of the external condyle identically like his one. He said that the deformity is due to the fractured piece being turned to an angle of 180 degrees, the surface looking toward the skin, and that there is but one way to remedy it—by open suture with reposition of the fragment. This was done, under cocaine anæsthesia, in the last two cases seen with perfect results.

#### REGENERATION OF THE RADIUS FROM ITS PERIOSTEUM.

The next patient, shown by the same speaker, was a splendid example of a regeneration of the radius from its periosteum. Two years ago the little patient sustained an ordinary Colles' fracture. At a nearby dispensary the arm was put up between an anterior and posterior splint, padded with cotton, the bandage including the hand almost to the finger-tips. As this happened in July and the boy was not told to return for three days, violent cellulitis of the arm developed. The boy was seen by the speaker



three days after being injured, and when the splint and dressings were removed two lines of lymphangitis starting from the interdigital clefts of the three outer fingers could be plainly seen. At the time of the injury the boy was playing on the street and the accumulation of germ filth in the interdigital clefts, under the moist perspiration induced by the dressing was the port of entry of the infection which caused the cellulitis. It was a practical demonstration of the fact that no fracture should be put up without the skin being in condition of surgical cleanliness. An analogy of this is seen in the infection of the glands of the groin from filth around the frenum, without any break in the mucus membrane. The entire radius necrosed and was removed. The boy has a strong arm, flexion, pronation, and supination being almost perfect, but there is considerable deformity.

The next patient was an example of Colles' fracture, the deformity not being corrected at the time of injury. There had been entire loss of function, immobilization of the wrist, loss of supination and pronation, as well as deformity. The operation consisted in chiseling through the line of fracture, the incision in the skin being placed on the dorsal end of the wrist rather than at the outer end of the radius, because of the uncertain position of the radial nerve. After correcting the deformity of the radius it is usually found that the hand is still in abduction and there is a projection of the lower end of the ulna, which can only be corrected by taking out a section of this bone. This had been done and all the motions of the wrist and forearm had returned and the deformity had been entirely corrected. This patient was operated on two years ago, and a second patient was also shown, operated on three months ago, with the same result. Casts were presented, showing the condition of the arm prior to the operation. A third patient was operated on three weeks ago. The after-treatment in these cases of ancient Colles' fracture is the same as in a recent fracture, that is, a straight splint on the posterior aspect of the arm and the hand carried into extreme abduction, with flexion of the wrist. The speaker did not believe it wise ever to put the arm between an anterior and posterior splint in Colles' fracture.

UNILATERAL ANKYLOSIS OF THE JAW.

Dr. Bodine also showed a patient, eighteen years of age, who, an attack of scarlet fever 16 years ago, followed by a suppurative parotiditis of the right side. A number of incisions were made to let out the pus, as the scars of the face showed. Unilateral ankylosis of the lower jaw followed. The patient had been brought up, throughout his childhood as well as his adolescence, entirely on liquid food, his teeth being closely in apposition. Some four years ago an attempt was made at one of the hospitals to relieve the condition. The scar of this operation was a clue as to what the surgeon attempted to do. The skin incision was above the exit of the facial nerve. Apparently a linear osteotomy was performed, but it failed to benefit the patient and permitting him to separate his jaws about a quarter of an inch. The speaker's incision was placed just above the angle of the jaw. The contracted soft parts were separated from the bone, and then, instead of a linear osteotomy, a triangular section of the ramus was removed, the base of the triangle being the posterior border. Still the patient could not open his mouth, and the points of scissors were passed through a cleft in the bone, the contracted internal pterygoid muscle clipped. The mouth could then be opened to its full extent. This case beautifully showed that sixteen years immobilization of a normal joint, that of the opposite healthy joint, does not produce ankylosis.

DEMONSTRATION OF SKENE'S METHOD OF ELECTRO-HAEMOSTASIS

as given by Dr. W. R. Pryor. He said that the celebrated Scotch surgeon, Keith, whose name was particularly associated with the removal of massive abdominal growths, treated the pedicles in the following manner: He grasped them with a powerful crushing-clamp, and by means of a superheated iron, heated the clamp so as not to burn the pedicle, but to cause it to become firm and parchment-like. In order that this might be accomplished, and yet not to apply too much heat, so as to produce dead tissue, as in an ordinary clamp and cautery operation, he had to exhibit an unusual acquaintance with the details. However, his pupil, Skene of Brooklyn, became impressed with the roughness of the hemostasis which Keith secured, with the

absence of pain in the stump, the absence of suppuration, and with the smooth convalescence of the patients, and having seen the complications which arise from the application of ligatures in certain situations, he, with the assistance of a skilled electrician, devised instruments for very simply doing what Keith did by a complicated technique, and with absolute precision.

The vessels to be obliterated are grasped with heavy forceps, very much like the pile clamp; adjacent tissues are protected either by means of a non-conducting shield or gauze pad, and as the clamp compresses the tissues a current of electricity is allowed to run through the clamp, heating it to about 190 degrees. Taking an ordinary ovarian pedicle as an example, a fair compression is secured for one minute; then for another minute more still, the instrument being all the while heated by means of electricity to 190 degrees. Upon removal of the clamp the pedicle is found converted into a tissue exactly similar in appearance to catgut, translucent, in thickness only  $\frac{1}{8}$  the original pedicle, perfectly dry and with the veins, arteries, nerves, and muscular fibres all coagulated into one mass, in which one can not be distinguished from the other. The softer the tissue, the slower should be the compression, and the less the time during which pressure should be applied.

“ When my attention was first drawn to this method, a number of years ago, I said that it would open up to the possibilities of the vaginal section in certain cases which had never been attempted that way, but I was unwilling to apply to my patients this method of controlling vessels until I had experimented. I therefore secured fresh arteries and sealed them by Skene's method. Upon subjecting them to hydrostatic pressure, I found that it required six times the normal amount of intra-arterial pressure to open up the mouths of vessels closed in this way; for instance, assuming that the pressure within an ovarian vessel is equal to three pounds, such pressure would have to be eighteen pounds, or greater than the aorta, in order to open the vessel. It is necessary, before applying any of these instruments, to have them thoroughly coated with sterile vaseline, otherwise they stick to the tissues.

"This method of occluding vessels should not be regarded as an absolute substitute for the ligation of large trunks by Wyeth's method of ligation in continuity, with approximation of the inner coats of the vessels without rupture, but it is a substitute for ligation of vessels in certain situations and under certain conditions. We all know the disadvantages of ligating en masse the cedematous and necrotic pedicle of a twisted ovarian tumor, of the broad ligament in an ectopic gestation associated with infection and edema. We also know the disadvantages of tying off a pus focus, such as gangrenous appendix or pyosalpinx. Again, in tying off certain very fragile pedicles, such as ectopic gestation or sepsis, we see our ligatures cut through the swollen and friable tissues, producing a disagreeable degree of bleeding. Again, in hemostasis in vesical and rectal polypi, erectile tissue about the vagina, in the tongue and spleen this method of hemostasis is far superior to any other. It has been found in the abdomen, where it is intended to perform intestinal section, that two broad lines of absolutely sterile and obliterated stumps can be approximated without the escape of a bubble of gas or feces to soil the suture-line; and afterward manipulation with two fingers opens the occluded ends, so as to make a continuous lumen. The twisted pedicle of an ovarian cyst, the infected pedicle of a dermoid cyst, and the highly vascular pedicle of a pedunculated fibroma may be removed by this method with absolute satisfaction and without the introduction of any suture material.

"In my hands its chief application in operations within the abdomen has been in the performance of my operation of total abdominal extirpation of the cancerous uterus and adnexa, with preliminary hemostasis, produced by ligation of the ovarians, fallopian tubes, and obturators, together with extirpation of the upper third of the vagina. Skene's method of electro-hemostasis is the only means of procedure by means of which I have ever been able to control bleeding from the erectile tissue about the vagina in this operation.

"It would seem to me an ideal method to apply in extirpation of the gall-bladder at its neck. The removal of the spleen, I believe, can be accomplished by this method with an insignificant

mortality because secondary hemorrhage is impossible and much time is saved. I find that my acquaintance with this method of hemostasis enables me to treat all my cases of ectopic gestation through the vagina and without abdominal section. I have yet to meet an ectopic gestation which I can not so treat, and can conceive of its failure only where the products of conception are too large a mass to pass the vaginal outlet. It has enabled me to remove dermoid cysts through the vagina and all ovarian cysts which were small enough to pass through this canal.

"I will now demonstrate to you upon this living animal this method of controlling bleeding. We will first take the small intestine, which in the dog is many times thicker than in the human being. Assuming that I wish to make a resection of the intestine or that I propose to close the two ends, where resection is to be followed by end- to-end or side- to-side anastomosis, I clamp the gut in two places and turn on the current. I push the clamp to the first notch, and at the expiration of half a minute we see a slight bubbling along the sides of the clamp. The heat produced is not too great for the touch, although it is disagreeable to the fingers. At the expiration, the camp is pushed down one more notch, and now the bubbling is quite energetic. After the second minute the clamp is pushed to the third notch, or as far as it will go, and the tissues show the escape of very little steam, but the structures touching the clamp have become white. In  $2\frac{1}{2}$  minutes the clamp is taken off and the stump inspected. On one side I find that I have not applied sufficient pressure and heat, whereas, on the other, the intestine which was grasped with the clamp is converted into a thin ribbon of translucent, parchment-like tissue. I reapply the camp for  $\frac{1}{2}$  minute to the other side, and the process is complete. Now, with scissors, I cut through these thin ribbons of tissue to see that the gut ends are absolutely closed. Without escape of gas and without escape of feces we have produced two stumps which are bloodless and uncontaminated by intestinal filth, and in which you can do such suturing as you see fit.

"The dog is pregnant, nearly to the full term, both cornua being filled with puppies. By manipulation I separate a portion of the uterine muscle and grasp it with the forceps, allowing

it to remain on three minutes. I then cut the uterine muscle and you will find absolutely no oozing. The large utero-ovarian artery which goes to one cornu, I purposely sever, so that you may see it spurt: then I grasp it with forceps and subject it to heat and pressure for two minutes and it is perfectly dry. Turning the animal over and pulling out the spleen, which in the dog has a head and quite a tail, I grasp it with the forceps at the point where it is about two inches wide, turn on the current, and by gradually increasing the pressure for one and a half minutes you will notice that this highly vascular organ is, at the point of pressure, converted into a thin sheet of parchment, through which one can almost see. With the scissors I sever this point and no blood escapes. I now take the large bunch of veins in one broad ligament, clamp them, heat them to 190 degrees for 1½ minutes, remove the forceps and cut the stump, and no blood escapes.

"Dr. Skene was not content with the results in more than two hundred applications of his method, and by experimentation and the use of the microscope in the hands of an expert microscopist he demonstrated that the pedicle never became infected and that the current in the vessels never became re-established: that, whereas the tissue did become organized, it always remained as a homogeneous mass, in which it was impossible to identify nerves, muscular tissue, mucous membrane, and vascular walls. My enthusiasm for this method of hemostasis is more than warranted, I can assure you, for I have applied it in double ovariotomy through the vagina, in the removal of pus sacs, in the removal of septic dermoid cysts, and many, many times in the removal of ectopic sacs, and in the removal of hemorrhoids and rectal polypi. I have found it to give me some satisfaction in work in the abdomen in the class of cases in which ligation is undesirable, namely, soft tissue, edematous tissue, necrotic tissue and septic foci.

"In transforming the current one may use either a liquid transformer and coil or an ordinary motor transformer; or one may employ a galvanic cautery-battery with the rheostat. As to the expense, I have found that I saved in the first four months I had the instruments what my ligature material would have cost

me. So far as the patient is concerned, not only is the method superior to application of ligatures 'under the circumstances in which it should be used, but the stumps are painless."

The paper of the evening on

THE PHYSIOLOGICAL FUNCTION OF MENSTRUATION AND THE PART  
PLAYED THEREIN BY THE FALLOPIAN TUBES,

was read by Dr. J. Riddle Goffe.

The various theories to account for menstruation and an interesting historical sketch were presented. The rut of animals was considered an analogous function to that of menstruation. The process in woman is considered analogous to the moulting of birds, the shedding hair and horns by the deer, and the shedding of leaves by a tree. All the processes of life go in circles, determined more or less completely by the environment. All quadrupeds as well as bipeds, experience a physiological function similar to menstruation, but the secretion does not appear externally in all of them. The appearance of the discharge in bipeds is due simply to posture, gravity bringing the discharge to the surface of the body. The same processes go on in quadrupeds, but on account of the position of the uterus it is retained in that organ, reabsorbed through the lymphatics into the blood, and finally consumed in the vital processes or eliminated through the excretory glands. In the native state wild animals experience a rut once a year, but domesticated animals, probably due to their environment and more luxurious care and keeping, experience the phenomena, or analogous phenomena, more frequently. The monkey has been observed to menstruate five times a year, and the cow to have a vaginal discharge at intervals of about three weeks. The monthly recurrence in women is thought to be due to her environment, and the result of civilization and its attendant luxuries. Life under these circumstances becomes more artificial; every factor in life is sought as a source of pleasure, and the race becomes more sexually inclined.

Menstruation is usually defined by the best authors as a monthly hemorrhage. The speaker offered the following definition: Menstruation is a frustrated attempt on the part of Nature to reproduce an individual of the species. The external sign of this is the menstrual discharge. Its *raison d'être* was described as



follows: An ovum is thrown out from the ovary and gradually finds its way toward the uterus. Nature at once begins preparations for its reception; the nervous system becomes exalted to a high degree of functional activity, the blood supply to these parts is increased; the endometrium, which is the soil in which the ovum is to be implanted, becomes turgid, soft and velvety, its epithelial cells swell and multiply, and every preparation is made to nourish the welcome guest and give it a home. If, on its way, the ovum has been fructified it is ready to respond to this bountiful preparation, takes root, and grows. But if the fecundation has failed, the guest is incompetent to receive the hospitality extended and is cast off. The preparations are also eliminated; the exuberant epithelial cells are exfoliated; the delicate capillaries sweat drops of blood by diapedesis, or burst and discharge their contents; the congested and engorged glands secrete and excrete profusely, and a thin mingled mass of epithelial cells, blood, and mucus comes away in the form of menstrual blood.

As a proof that some of the menstrual discharge comes from the Fallopian tubes, two cases occurring in the author's private practice were narrated. Both patients had been subjected to vaginal hysterectomy, and in each instance the ovary and tube on one side had been left in situ. In removing the pelvic drain during convalescence, the proximal end of the tube in each case was accidentally dragged down into the vagina and caught in the the operation, and the blood was seen to trickle into the vagina from the open ends of the tubes. These observations were continued for several months, and then, in fear of the possibility of tubal pregnancy, the ends of the tubes were sealed up. Experience in these cases seemed to establish so far as such observation can, the fact that the tube, at least in the absence of the uterus, actually performs the function of menstruation.

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**MEDICINAL TREATMENT OF GALLSTONES.**—H. Richardson says that glycocholate of sodium will dissolve gallstones in the bladder, and even when cholecystitis is present glycocholate of sodium is indicated not only as a prophylactic but as a solvent for stones already present, and that in those cases only in which there is occlusion of the gall-duct is surgical interference permissible.—*Therapeutic Gazette*.



## THE TREATMENT OF BOILS AND FELONS.

BY L. BENNETT, M. D., CENTRAL CITY, KY.

Boils may occur singly or in crops, and they seem to show a predilection for the axilla, the back, buttocks, legs, and the face. Boils are often associated with the unfolding of diabetes, and other diathetic conditions stand in causative relationship. There seem to be two classes of boils, one being a simple local inflammation due to irritation about a sebaceous gland. The other begins deeply, and owes its existence to a localized depressed state of resistance in the cellular element of the skin and subcutaneous tissue. Felons, or whitlows, are also seen with great frequency, and the pain and anguish they produce is very great. In fact it may be said of boils, and of felons also, that they are most painful, and that they carry in their train as much physical woe as many of the graver disease conditions. Felons may be defined as inflammation of the tendons beginning at the end of the finger, still the term felon is employed by good observers to mean a suppurative inflammation of the cellular tissue of the pulp of the finger-tip, or as Roberts puts it, "a simple abscess in fact." The treatment of boils and felons is indeed a matter of great importance. Some writers advocate a system of treatment having for its object the abortion of boils and felons. These observers advocate the painting of the surface of the developing boil or felon with tincture of iodine, or injecting it with carbolic acid. An extensive experience with both of these means of aborting boils and felons has been to convince me that they are entirely without merit. In some cases they have caused cutaneous inflammation which produced in itself great distress. For the last few years I have quit trying to abort the boil by this means. I use my efforts in these cases to correct the dyscrasia of the blood, which is responsible for the appearance of the boil. In this way boils and felons are easily brought under control, and the patient's physical condition is brought to a higher standard. In the first place, when a patient with a boil presents himself, we should begin with the internal administration of echol in doses of a teaspoonful every two or three hours.

This has in a considerable number of cases corrected the dyscrasia of the blood, which is responsible for the appearance of the boil or felon, and the course of the disease was greatly shortened. In those cases where we have a patient with a crop of boils, ecthol will bring about a cure of the morbid process quickly. This is a matter of great importance, since I never was before able to render any substantial assistance to these patients. But let me now speak of the needed attention to the boil or felon itself. If the boil has begun to suppurate it should be opened and all of the diseased tissue should be curetted away. The cavity then should be well cleansed with pure peroxide of hydrogen and filled with absorbent cotton saturated with ecthol. Over this should be put a bandage and this dressing should be reapplied every four or six hours. The local action of ecthol is a highly beneficial one and should always be brought to our assistance. It tends to stimulate healthy action in the diseased tissues. The treatment of the felon itself is of course to be substantially the same. During the time the patient is suffering we can give nothing equal to papine to relieve pain. It does not derange the secretions as the old time opiates, but is a powerful antagonist to pain. These patients are required to continue the use of ecthol for some two weeks or more after the boils or felons have disappeared, as a corrective of the blood. This is the treatment that has been so successful in my hands that I feel that I want the profession in general to give it an extended trial. Mr. R. H. M., who is about fifty years of age, having a large boil on his wrist, and two or three other smaller ones on his arm, came to me for treatment. I put him at once on ecthol in doses of a teaspoonful every three hours, and opened the largest boil and used ecthol locally as already described. This healed up quickly and the smaller boils that were just coming on never attained much size and were easily disposed of. No new boils appeared, and the patient's general health improved greatly, and he has since enjoyed fine health.

Mrs. S. O. E., age thirty-one.—This lady had a boil just at the lower border of her lip; this caused her great pain, and rendered it almost impossible for her to eat. She was put on ecthol in doses of a teaspoonful every three hours and the inflammation

was hastened by poultices, and the boil was opened, curetted, and treated with peroxide of hydrogen and ecthol locally as already described.

This speedily brought the boil to cure, and several other boils that were beginning at the time of her attack, faded away.

S. M. S., age nineteen.—This girl came to me for relief for a felon that was causing her great anguish. She was given papine in doses of a teaspoonful to relieve the pain. Ecthol was taken in doses of a teaspoonful every three hours. The felon after being poulticed all night was opened and curetted and ecthol was applied regularly. This produced a rapid cure and the patient had no further trouble, but has since had excellent health.

Mr. R. D. K., age twenty, suffered from a felon which was the result of an injury. This patient had also had boils and his blood was in a bad condition. He was treated substantially in the same way as the other patients just mentioned, and made a quick recovery. This young man saw me yesterday and said his health, since this treatment a year ago, had been most excellent.

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## *Records, Recollections and Reminiscences.*

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### THE ASSOCIATION OF MEDICAL OFFICERS OF THE ARMY AND NAVY OF THE CONFEDERACY.

The Seventh Annual Meeting of the Association will convene in the building of the Medical Department of the University of Tennessee, situated on Broad Street, between High and Vine Streets, about two blocks east of the Terminal Station, on Tuesday morning May 14th, at 10 o'clock, and will be called to order by Dr. Geo. H. Price, Chairman of the Committee of arrangements. The other members of the Committee of Arrangements are Drs. Paul F. Eve, W. G. Ewing, Geo. C. Trawick, and D. R. Neil.

The following constitute the various sub-committees:

*Invitation:* Dr. Duncan Eve, Chairman; Drs. Thos. L. Maddin, Thos. Menees, A. M. Trawick, J. R. Buist, J. Bunyan Stephens, and M. D. Kelley.

*Reception:* Dr. Jno. S. Cain, Chairman; J. A. Beauchamp, J. B. Neil, R. B. Lees, W. B. Maney, I. C. Loftin, W. A. Atchison, A. A. Lyon.

*Entertainment, Refreshment, and Hall:* Dr. D. B. Blake, Chairman; S. S. Crockett, Richard Douglas, C. A. Robertson, R. E. Fort, W. A. Witt, M. C. McGannon.

*Finance:* Dr. G. C. Savage, Chairman; Jas. B. Stephens, J. Y. Crawford, Y. W. Haley, J. F. Rowland, W. G. Black, R. O. Tucker, P. McF. Allen, D. R. Neil.

All members of the Association, and all who served in the Medical Department of the Army or Navy of the Confederate States as Surgeon, Assistant Surgeon, Hospital Steward, or Chaplain; and all regular Doctors of Medicine who are Confederate Veterans, or sons of Confederate Veterans, who may wish to become members of the Association are requested to come at once to the building in which the meeting will be held, on their arrival in the city.

The succeeding sessions after that of Tuesday morning will be determined from time to time, so as not to conflict with the other Re-Union exercises.

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## *Editorial.*

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### COUNTY MEDICAL SOCIETIES IN THE STATE OF TENNESSEE.

The following societies have been regularly chartered by the Tennessee State Medical Association. The names of the presidents and secretaries with their post-offices are also given.

Anderson — S. B. Hall, M. D., President, Clinton; E. M. Beasley, Secretary, Coal Creek.

Bedford — G. W. Moody, M. D., President; F. B. Reagor, M. D., Secretary, Shelbyville.

Benton — W. T. Hubbs, M. D., President; W. P. McGill, M. D., Secretary, Camden.

Bradley — G. M. Bazemore, M. D., President; T. J. McKamy, M. D., Secretary, Cleveland.

Campbell — I. J. Shepherd, M. D., President; J. U. Roach, M. D., Secretary, LaFollette.

Cannon — L. B. McCreary, M. D., President; J. R. Doak, M. D., Secretary, Woodbury.

Carroll — J. W. McCall, M. D., President; C. T. Love, M. D., Secretary, McLemoresville.

Chester — J. B. Hardiman, M. D., President; I. E. Perkins, M. D., Secretary, Henderson.

Claiborne — H. C. Chance, M. D., President, Cumberland Gap; N. H. Stone, M. D., Secretary, Tazewell.

Coffee — A. F. Vincent, M. D., President; E. P. Vaughn, M. D., Secretary, Manchester.

Crockett — H. W. Cook, M. D., President, Alamo; F. P. Hess, M. D., Secretary, Bells.

Davidson — S. S. Crockett, M. D., President; Deering J. Roberts, M. D., Secretary, Nashville.

Decatur — W. G. Raines, M. D., President, Parsons; R. Y. Fisher, M. D., Secretary, Decaturville.

Dickson — W. S. Scott, M. D., President; W. W. Walker, M. D., Secretary, Dickson.

Dyer — T. J. Walker, M. D., President; N. S. Walker, M. D., Secretary, Dyersburg.

Fayette — D. M. Morrow, M. D., President, Oakland; H. C. Moorman, M. D., Secretary, Somerville.

Franklin — F. B. Sloan, M. D., President, Cowan; G. S. Warren, M. D., Secretary, Decherd.

Gibson — J. C. Paris, M. D., President, Kenton; B. T. Bennett, M. D., Secretary, Trenton.

Giles — A. W. Deane, M. D., President, Brickchurch; C. A. Abernathy, M. D., Secretary, Pulaski.

Greene — C. P. Fox, M. D., President; S. W. Woodyard, M. D., Secretary, Greeneville.

Hamblen — P. L. Henderson, M. D., President; H. M. Cass, M. D., Secretary, Morristown.

Hamilton — \_\_\_\_\_; J. W. Johnson, M. D., Secretary, Chattanooga.

Hardeman — J. D. Sasser, M. D., President, Middleton; R. W. Tate, M. D., Secretary, Bolivar.

Hardin — R. A. Hardin, M. D., President; W. E. McDougall, M. D., Secretary, Savannah.

Haywood — H. P. Hudson, M. D., President, Hanley; J. L. Edwards, M. D., Secretary, Brownsville.

Henderson — J. C. Stinson, M. D., President, Center Point; C. H. Johnson, M. D., Secretary, Lexington.

Henry — R. A. Grainger, M. D., President; J. H. McSwain, M. D., Secretary, Paris.

Hickman — D. W. Flowers, M. D., President, Little Lot; J. T. Ward, M. D., Secretary, Centerville.

Houston — A. H. Abernathy, M. D., President; W. H. McMillan, M. D., Secretary, Erin.

Humphreys — J. T. Cooley, M. D., President, Plant; W. W. Slayden, M. D., Secretary, Waverly.

Jefferson — I. M. Tittsworth, M. D., President, Jefferson City; B. F. Brown, M. D., Secretary, Mt. Horeb.

Knox — C. M. Capps, M. D., President; C. H. Davis, M. D., Secretary, Knoxville.

Lake — J. W. Wright, M. D., President; J. L. Hutchinson, M. D., Secretary, Tiptonville.

Lauderdale — A. H. Young, M. D., President; G. A. Lusk, M. D., Secretary, Ripley.

Lincoln — J. T. Graham, M. D., President, Booneville; H. W. Heyman, M. D., Secretary, Fayetteville.

Loudon — J. J. Harrison, Jr., M. D., President, Loudon; J. T. Leiper, M. D., Secretary, Lenoir City.

Madison — J. T. Jones, M. D., President; H. Hawkins, M. D., Secretary, Jackson.

Marshall — W. C. Ransom, M. D., President, Farmington; T. E. Reid, M. D., Secretary, Lewisburg.

Maury — M. M. Cook, M. D., President, R. F. D No. 8, Columbia; O. J. Porter, M. D., Secretary, Columbia.

Monroe — W. A. McClain, M. D., President; A. D. Scruggs, M. D., Secretary, Sweetwater.

Montgomery — J. W. Brandau, M. D., President; R. B. Macon, M. D., Secretary, Clarksville.

Morgan — D. W. Cooper, M. D., President; N. L. French, M. D., Secretary, Wartburg.

Obion — H. T. Butler, M. D., President; F. W. Watson, M. D., Secretary, Union City.

Perry — I. N. Block, M. D., President, R. F. D. No. 3, Linden; J. P. Dabbs, M. D., Secretary, Linden.

Polk — F. M. Kimsey, M. D., President; L. E. Kimsey, M. D., Secretary, Ducktown.

Putnam — J. T. Moore, M. D., President, Algood; S. D. Davis, M. D., Secretary, Cookeville.

Rhea — W. P. McDonald, M. D., President, Spring City; R. C. Miller, M. D., Secretary, Evensville.

Roane — J. A. Sewell, M. D., President, Rockwood; G. C. G. Givan, M. D., Secretary, Harriman.

Robertson — G. W. Menees, M. D., President; B. F. Fyke, M. D., Secretary, Springfield.

Rutherford — H. C. Rees, M. D., President; Rufus Pitts, M. D., Secretary Murfreesboro.

Sevier — D. E. Walker, M. D., President; F. S. Caton, M. D., Secretary, Sevierville.

Shelby — Edwin Williams, M. D., President; J. L. Barton, M. D., Secretary, Memphis.

Stewart — F. M. Acree, M. D., President, Dover; J. B. LaHiff, M. D., Secretary, Indian Mound.

Sumner — X. B. Haynie, M. D., President; W. N. Lackey, M. D., Secretary, Gallatin.

Tipton — O. M. Walker, M. D., President, Munford; B. V. Dickson, M. D., Secretary, Covington.

Trousdale — A. G. Donohoe, M. D., President; A. G. Donohoe, Jr., Secretary, Hartsville.

Warren — Albert Seitz, M. D., President; T. O. Berger, M. D., Secretary, McMinnville.

Washington — W. J. Matthews, M. D., President; C. J. Broyles, M. D., Secretary, Johnson City.

Wayne — G. C. Grimes, M. D., President; F. H. Norman, M. D., Secretary, Waynesboro.

Weakley — R. W. Bandy, M. D., President, Gleason; R. M. Little, M. D., Secretary, Dresden.

White — L. D. Cotton, M. D., President, Amanda; A. F. Richards, M. D., Secretary, Sparta.

Williamson — J. B. Core, M. D., President, Bethesda; S. W. White, M. D., Secretary, Franklin.

Wilson — J. W. McFarlan, M. D., President; A. O. Eskew, M. D., Secretary, Lebanon.

#### A JUST DECREE.

At a Special Term, Part II., of the Supreme Court of the State of New York, held at the Court House in the County of New York, on May 6, 1904. Hon. Henry Bischoff, Justice, rendered the following decree. It needs no comment at our hands, only we would like to see a little more of like character.

"Ordered, Adjudged, and Decreed as follows: *First*: That the plaintiff, The M. J. Breitenbach Company, is the owner of the sole and exclusive right to the use of the words 'Pepto-Mangan' as a trade mark and trade name, as applied to medical preparations, throughout the United States and Canada, and has the sole and exclusive right in the same countries, of putting up and selling the preparation known as Gude's 'Pepto-Mangan,' according to the secret process and formula discovered by Dr. A. Gude, of Leipsic. *Second*: That the said defendants the Siegel, Cooper Company and Thomas H. McInnerney, their agents, servants, employees, and attorneys, be and they hereby are forever enjoined and restrained from making use of the words 'Pepto-Manganate' in any manner whatsoever, either alone or in combination with other words, or from using the words 'Pepto-Mangan,' or any word or words similar to the words 'Pepto-Mangan' in sound or appearance, in connection with the advertisement or sale or otherwise, of any medical or other preparation—excepting only that of the plaintiff. *Third*: That the said defendants the Siegel, Cooper Company and Thomas H. McInnerney forthwith deliver to the plaintiff, or its attorney, to be destroyed, all bottles, packages, wrappers, circulars, or other things in their possession or under their control, or that of either of them,

bearing the words 'Pepto-Manganate,' or any similar words. *Fourth:* That the said plaintiff the M. J. Breitenbach Company recover of the said defendants the Siegel, Cooper Company and Thomas H. McInnerney the damages, to be assessed by the Court, resulting from the use by the said defendants of the name 'Pepto-Manganate,' which is hereby adjudged to be a violation of the plaintiff's rights in the name 'Pepto-Mangan.' *Fifth:* That the plaintiff recover from the said defendants the costs of this action."

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**TYREE'S ANTISEPTIC COMPOUND:**—This is a powder which combines strong antiseptic powers with an exceptionably agreeable odour. It is composed of borate of sodium, albumen, carbolic acid and glycerine together with the crystalized principles of thyme, eucalyptus, gaultheria, and mentha. It is used (in the proportion of a heaped teaspoonful to a pint of warm water) for local application to wounds and sores, for cleansing discharging mucous membranes and for disinfecting the upper air passages in catarrhal states. Although it has this very wide sphere of usefulness it has been found to have an almost specific influence upon morbid conditions of the genito-urinary tracts. Gonorrhoea, Leuchorrhoea, and Pruritis due to irritating discharges in women speedily yield to it, and as being practically non-poisonous, it has great advantages over those substances similarly used which, though of acknowledged efficacy, are nevertheless in the hands of the ignorant by no means free from danger. Its very agreeable odour will recommend it to many for use as any ordinary domestic antiseptic powder in substitution for the crude preparations which are not generally employed for this purpose. Reprinted from Chrystie's Monthly, London, England.

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**VIN MARIANI** is a proprietary preparation only in name. It stands for originality and reliability, representing just what it is claimed to be. Perfection is attained under expert possibilities with machinery which is the outgrowth of long years of specialism confined exclusively to Coca products. Numerous endorsements, from physicians in various parts of the world who are using Vin Mariani in daily practice, praise its unique qualities as a tonic and restorer of nervous and muscular strength. Vin Mariani was used by the profession fully twenty years before cocaine was known in medicine. In fact, through this preparation physicians were made familiar with the properties of Coca, and this was the original and only available form of employing the remedy. The popularity of Vin Mariani has led imitators to foister upon the profession artificial substances concocted by adding cocaine to wine. Such base frauds masquerading as Coca Wine—a title originated by M. Mariani—have done grave evil and tend to unjustly cause condemnation of all Coca preparations as but false products.

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**HYSTERIA** is the expression of one form of nervous debility. Celerina is thus peculiarly indicated because of its tonic effect on the whole nervous system.



**FAULTY ELIMINATION** is a prolific source of trouble and the cause of many distressing symptoms pointing to no definite lesion, but complicating and obscuring the actual symptoms of a real disease. Such a condition is puzzling to the doctor and discouraging to the patient, often causing dissatisfaction with the treatment and lack of confidence in the physician, yet the whole train of symptoms may be only the result of a lowering in the tone of the secretory organs and the retention of poisonous material in the system. In all conditions which follow as a result of the blocking of the eliminative organs, such as colds, bronchial catarrh, la grippe, pneumonia and autotoxia, one of the first indications is to bring the eliminating organs up to the normal and put them in condition to perform their natural duty. A large proportion of the cases which doctors are called upon to treat during the winter and in the spring are furnished by neglected colds and after effects of la grippe. These uncured affections keep the system open to new attacks, the patient develops a bronchitis, or pneumonia, the kidneys are affected and sometimes left permanently weakened. A cold is by no means a simple affair which, left to itself, will always speedily get well. The acute stage will probably spend itself, and the patient may think he is free from further trouble, but such attacks render him more liable to further infection, and pneumonia, chronic bronchitis, and chronic kidney disease are some of the sequelæ of frequent colds. Therefore, these apparently harmless colds are to be taken seriously and cured absolutely as soon as possible. To cut short these attacks and restore the tissues to normal powers of resistance the Dad Chemical Co., of New York commend Respiton. It contains *asclepias tuberosa* and *berberis*. A teaspoonful in a glass of hot water every two hours will effect a complete cure in a few days.—*Interstate Medical Journal*, April, 1904.

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**ENURESIS, GLEET, AND IRRITABLE PROSTATE.**—Dr. N. S. Wood, Anderson, Ind., says, "I find that Satyria is a most excellent tonic and reconstructive remedy. I find it very useful in children's diseases, especially in enuresis it is fine." July 24, 1903.

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**THE MODIFICATION OF COW'S MILK.**—Looking at the analyses of milk, it would seem that a small addition of water to cow's milk brings it down to human milk; while some contend for a small addition of sugar. Nor need necessarily the sugar be cane sugar; a little maltose is easily procurable as in Mellin's Food for instance. The advantage of malt sugar in whatever form to the milk is that malt sugar rather undergoes lactic acid fermentation, while cane sugar undergoes acetous fermentation—and acetic acid is far more irritant than lactic acid, whether free or in combination with a base.—*Fothergill's "Manual of Dietetics."*

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**CHOLERA INFANTUM**—When an internal mucus astringent is indicated, in such cases as Cholera Infantum, etc., Kennedy's dark *pinus canadensis* should be given in an alkaline medium.

**THE PAIN IN RHEUMATIC GOUT.**—Chas. P. Heil, M. D., late Professor of Anatomy, Indiana College of Medicine, Indianapolis, Ind., in the *Mobile Medical and Surgical Journal* says: "Many of the cases of rheumatic gout which I have treated were of an obstinate and complicated character and I must state that I myself have been suffering with an attack in the nature of a very severe inflammatory condition, situated in and over the articulations of my wrist, knee, and ankle joints. The pain which I suffered most of the time was indescribable. I placed myself under the care of a physician, who, upon examination, pronounced me also slightly affected with cardiac trouble. I suffered the most excruciating pain for ten days and nights, without alleviation of my sufferings; nor apparent signs of progress for the better. Knowing full well the efficiency and value of Antikamnia Tablets in these cases, I took two tablets and about ten minutes after taking them the pain was relieved, I perspired slightly and then fell into a gentle sleep. The result was simply magical. I slept eight hours in perfect rest, free from all pain. I continued the two tablets every four hours during my convalescence and until complete recovery."

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**THE SIXTH ANNUAL MEETING OF THE AMERICAN PROCTOLOGIC SOCIETY** will be held at Seaside Home, Atlantic City, June 8th and 9th, inst. A very attractive and interesting program has been arranged by the Secretary, Dr. A. B. Cooke, of Nashville, Tenn. Dr. Wm. M. Beach of Pittsburgh, Pa., is the President. All members of the Regular Medical Profession are cordially invited to attend the meetings.

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## ***Reviews and Book Notices.***

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**A PRACTICAL TREATISE ON MEDICAL DIAGNOSIS FOR STUDENTS AND PHYSICIANS**, by John H. Musser, M. D., Professor of Clinical Medicine in the University of Pennsylvania; Physician to the Philadelphia and Presbyterian Hospitals; Fellow of the College of Physicians of Philadelphia; Member of the Association of American Physicians; President of the American Medical Association; etc., etc. Fifth Edition, Revised and Enlarged, 8vo. cloth, pp. 1213. Illustrated with 395 word-cuts and 63 colored plates. Lea Bros. & Co., Publishers, Philadelphia and New York, 1904.

This work is an exponent of objective medicine, and points out the way to acquire precision in diagnosis by modern methods. In the earlier editions great stress was placed on bacteriological

diagnosis and the principles that underlie it, the object being to impress upon the profession the essential advantages to be derived from this method. That which was then a new story is now universally recognized, and in the present handsome edition the principles of diagnosis have yielded space for greater elaboration of the practical features. So many new and valuable methods have been developed, and so many new points of importance have arisen, that in spite of earnest efforts at condensation, the information presented has required increase of space. Laboratory methods, the application of the X rays, and the latest developments of physical diagnosis have been thoroughly and especially considered.

The work is divided in accordance with the natural employment of the methods, giving in sequence historical diagnosis, subjective, objective, physical, and laboratory diagnosis. By observing these methods closely, we reach not only the disease, but also the health value of the patient, upon which restorative efforts are to be based. Dr. Musser's great and varied experience as a teacher and consultant make this splendid work of more than usual value to both students and practitioners.

The illustrations, paper, press-work, and binding are a fitting *entourage* of so valuable a work.

MANUAL OF CLINICAL MICROSCOPY AND CHEMISTRY, prepared for the use of Students and Practitioners of Medicine. By Dr. Hermann Lenhartz, Professor of Medicine and Director of Hospital at Hamburg, etc. Authorized Translation from the Fourth and Last German Edition, with Notes and Additions, by Henry T. Brooks, M. D., Professor of Histology and Pathology at the New York Post-Graduate Medical School and Hospital; Member of the New York Academy of Medicine, etc. With 148 Illustrations in the text and 9 colored plates. Pages xxxii-412, octavo. Bound in extra cloth. Price, \$3.00, net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This volume is the outcome of Prof. Lenhartz' work as a teacher, and considers very fully and practically Clinical Microscopy and Chemistry.

Chemistry has received detailed consideration especially in connection with examination of the urine; in the study of the blood, gastric contents, etc., practical tests including forensic examination have been considered. In the first part of the book

the vegetable and animal parasites have been briefly dealt with, and the consideration of the sputum, urine, and other secretions and excretions have been handled in a comprehensive and thoroughly practical manner.

This edition has been very thoroughly revised, some additions made by the translator are included in brackets; and among the author's additions are cryoscopy, the bacillus dysenteriae, the paratyphoid bacillus, a new method of staining the blood, and an addition to the section on Widal reaction. The work in its present shape represents the results of nearly a quarter of a century's work by one of the most able and competent German diagnosticians and teachers.

**MANUAL OF MATERIA MEDICA AND PHARMACY.** Specially designed for the use of Practitioners and Medical, Pharmaceutical, Dental, and Veterinary Students. By E. Stanton Muir, Ph. G., V. M. D. Instructor in Comparative Materia Medica and Pharmacy in the University of Pennsylvania. Third Edition, Revised and Enlarged. Crown Octavo, 192 pages, interleaved throughout. Bound in extra cloth, \$2.00 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This work gives to students and practitioners in a clear and concise manner, those points which are of value in practical pharmacy, without going into the lengthy details usually found in text-books. Leaving out old, obsolete, and useless drugs and preparations, only those of recognized therapeutic value and every-day use are considered.

Part III, devoted to pharmacy, will familiarize the student with the processes used in pharmaceutical work, together with the preparations, especially those which are compound.

The drugs are arranged in alphabetical order, and the Metric System is used, primarily, because it is becoming more and more employed every day.

**A GUIDE TO THE CLINICAL EXAMINATION OF THE BLOOD** for Diagnostic Purposes, by Richard C. Cabot, M. D., of Boston. Fifth Revised Edition, 8vo. cloth, pp. 549; with colored plates and engravings. Wm. Wood & Co., Publishers, New York, 1904.

The usefulness of Hematology is now well settled, and it can claim for itself a special field of material value in the do-

main of medical science. While there are but few diseases in which it alone will prove diagnostic, yet as an aid, as confirmatory to other clinical factors and laboratory procedures its value is now well established. While positive pathognomonic signs can be found by the most critical examination of the blood in but few instances, yet in many it furnishes some of the strongest links in the chain of evidence giving us a certain knowledge of various pathological conditions.

Dr. Cabot has given us a most valuable treatise on this subject, clear, practical, and reliable, with the latest developments and most improved and accepted technique. The many illustrations and plates greatly enhance its value.

In this fifth edition, we find about ninety pages added, with about twenty eliminated. The most important changes are due to the introduction of the Romanowsky staining method (Jenner, Leishman, and others), as applied to routine blood examination. A new set of colored plates has been prepared from specimens stained in this way.

Considerable additions will be found in the chapters on infectious diseases and blood parasites, with minor changes on nearly every page, for the revision has been thorough.

**GRAVES' DISEASE**, with and without Exophthalmic Goitre, by William Hanna Thompson, M. D., LL. D., Physician to the Roosevelt Hospital, New York; Consulting Physician to the Manhattan State Hospital for the Insane; formerly Professor of Practice of Medicine in the New York University Medical College, etc., etc. 8vo., cloth, pp. 143. Wm. Wood & Co., Publishers., New York. 1904.

In this excellent Monograph Dr. Thompson claims that the constitutional and general derangements that characterize Graves' Disease, constitute the disease, and not the condition of the Thyroid gland or its accessories.

He gives the clinical histories of forty-two patients who did have Exophthalmic Goitre, and twenty-eight who did not have it, comparing them symptom by symptom. This comparison is made to demonstrate that there is no connection between this disease and a pathological condition of the Thyroid Gland. We can earnestly recommend the work to those interested in a study of this disease.

**INTERNATIONAL CLINICS**, A quarterly of Illustrated Clinical Lectures and especially prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Obstetrics, Gynecology, etc., etc. By leading members of the Medical Profession throughout the World. Edited by A. O. J. Kelly, A. M., M. D., of Philadelphia. 8vo., cloth, pp. 304. Vol. 1. Fourteenth Series. 1904. Price, \$2.00, J. B. Lippencott Co., Publishers, Washington Square, Philadelphia, Pa.

This is a magnificent number of the International Clinic Series. It is indeed remarkable that the publishers can publish in such a handsome maner, so well bound, and beautifully illustrated, such a valuable amount of medical literature for the small sum of only two dollars.

Among the especially attractive and valuable articles in this number may be mentioned "The Therapeutic Application of Colloid Silver," by Drs. Netter and Salomon; "The Early Diagnosis of Pulmonary Tuberculosis," by Jas. H. Walsh; "Intestinal Anadtomosis," by Jno. G. Clark and Jno. W. Luther; "Gastric, Intestinal, and Liver Surgery in the German Clinics," by Chas. P. Noble; "Progress of Medicine During 1903," by David L. Edsall. These are but a few of the valuable contributions in this number, any one of which is worth more than the price of the volume.

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## *Selections.*

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**BRIEF OBSERVATIONS ON SOME CONDITIONS IN WOMEN THAT ARE OF MUCH CONCERN TO THE PRACTITIONER.**—The conditions of which I wish to speak are dysmenorrhea, and the state following miscarriage or abortion, in which there are retained portions of the placenta and membranes that require removal or expulsion.

For lack of space, I shall devote myself, in the present paper, chiefly to dysmenorrhea, and will dismiss the condition following abortion with a few remarks, which may as well precede the other part of my article. I reserve for a future communication the detailed discussion of this important and interesting clinical condition.

The effects of retained placental or fetal tissue in a partially successful miscarriage or abortion consist in hemorrhages, purulent discharge, enlargement of the uterus, subinvolution, metritis, endometritis and sepsis. The indications in these cases are, therefore, the thorough emptying of the uterus and the rendering of the womb-cavity aseptic.

In ordinary cases this must be done by surgical interference, including curetting and the removal of all decomposing and diseased tissue, followed by the application of antiseptics to the endometrium. There is a class of cases, however, in which for one reason or another curettage is refused by the patient, and in which it is incumbent upon the physician to give what relief he can by medical means. In such cases I have prescribed Ergoapiol (Smith), a combination of the active principles of ergot (ergotine) parsley (apiol) and certain other emmenagogues and uterine tonics. In one case of this kind which came under my observation some months ago, I used Ergoapiol (Smith) with such marked success, that I learned since then to rely upon this preparation in removing the retained fragments from the uterus, emptying the organ and reducing it to its normal size and functions. The remedy in question has proved so trustworthy in my hands in these cases, that when it disappoints, which it rarely does, I look about to ascertain wherein I myself have erred.

A discussion of the causes of dysmenorrhea would lead us too far in the present brief clinical paper, and it will suffice if I assume that the reader is acquainted sufficiently with this part of the subject to follow me in the remainder of the article. The clinical diagnosis of dysmenorrhea is in itself easy enough, while the diagnosis of the cause is not always so simple. In the cases presented here I paid especial attention to the causation of the menstrual pain, as I believe that in this manner I was better able to outline the indications for treatment. It goes without saying that dysmenorrhea from mechanical obstruction is not amenable to medical treatment. Fortunately, however, it has been in my experience at least, not frequent, as dysmenorrhea depending upon congestion. The specially disagreeable and intractable form of dysmenorrhea which is accompanied by a fetid discharge as a result of the decomposition of the retained menstrual blood, also comes under discussion here, as the use of douches with antiseptics



and deodorants cannot be hoped to affect it permanently, while the employment of more radical medicinal means does bring about the desired effect in this condition.

In congestive dysmenorrhea, and in that form which is accompanied by fetid discharge, the indications are to diminish congestion, by promoting the contractions of the uterus and relieving it of the accumulated blood, to stimulate glandular activity in the mucosa, to restore the tone of the uterus and the nutrition of its tissues to normal, and to relieve spasm and pain.

The following cases illustrate the effects which I obtained with the use of Ergoapiol (Smith) in the treatment of dysmenorrhea:

Some months ago I was consulted by a young woman who had suffered from scanty, fetid menstruation, accompanied by a great deal of pain, since the birth of her first child seven years previously. Her labor had been followed by a tear of the perineum which had been left unrepaired, and also a laceration of the cervix uteri. This patient consulted a specialist, but his treatment did not give her relief. Examination revealed the presence of the uterine and perineal lacerations already mentioned, and disclosed a chronic endometritis that had given rise to a fetid discharge and to pain during each menstrual period. I repaired the tears, curetted the uterus, and hoped in this manner to obtain permanent relief of the patient's symptoms. After she had recovered from the operations, she declared that she was feeling better than she had been for years. But very soon the fetid discharge and the pain returned at each menstrual period, and evidently something else had to be done if I wanted to save my reputation. I then tried local applications, alteratives, uterine tonics, etc., all without avail, until finally Ergoapiol (Smith) was given. The result was immediate relief and a gradual and permanent improvement in the menstrual flow until it was free from pain and devoid of any disagreeable odor.

This patient was evidently suffering from congestive dysmenorrhea which was intensified by the presence of lacerations of the cervix and the perineum which had existed since parturition. The result attained illustrates very well how Ergoapiol (Smith) acted upon the uterus, restoring its tissues to normal condition and re-establishing the menstrual function upon its normal basis.



Another type of dysmenorrhea, that which I term "nervous," but which the authorities term "neuralgic," is illustrated by the following case which recently came under my care:

The patient was a young woman who had been married two years, but had not borne any children. She stated that she had pain during the menstrual period from the first onset of menses, and at the time of examination she also complained of a fetid discharge. The menstrual flow was scanty and rarely of blood red color. Just before and after the period she had backache and headache, her complexion was unhealthy, not bright and clear as that of her sister, and she appeared older than she really was. She always dreaded the onset of the menses which recurred with a regularity that is not always present in these cases. She was easily excited, and received impressions vividly and indelibly. Her digestion was poor, and she was often sleepless, irritable, and peevish.

Vaginal examination revealed a slightly thickened os and slight endocervicitis with erosions of the cervix. Cod liver oil, malt extract, hypophosphites, and aromatics, in combination, 25 per cent. of each, were given freely during the intervals between the menstrual periods and for three days before the expected menstruation Ergoapiol (Smith) was given in capsules, one being given three times daily until the discharge ceased. At the fourth period after the beginning of the treatment she was relieved of all her symptoms, and was free from pain and fetor during menstruation. Locally, tincture of iodine and occasionally tampons of ichthyol and glycerine were applied. The cure was permanent and in every way satisfactory.—J. Ridgely Simms, A. M., M. D., in *Medical Herald*.

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REMARKS ON GLYCO-THYMOLINE.—For many years past this preparation has been one of my mainstays in diseases of the mucous membranes, and it has held its place despite the trials of many other agents warranted to supplant it by the advocates who decried glyco-thymoline when I spoke of its virtues. Space is now getting too valuable to waste with long detailed descriptions of separate cases, and anyhow I never did write in that manner—I think general remarks about agents is the better way, and we need this more than stories of symptoms and temperatures, with daily alterations. No class of maladies is more troublesome than disorders of the

mucous membranes, and none more difficult to eradicate thoroughly, and we have been put to our wit's end many times for remedial agents in such cases. The local treatment of catarrhs is frequently disappointing, and none more so than that prevalent one—post-nasal catarrh. Unless we can get an alterative condition established little good is done, and nothing has been of greater service to me than glyco-thymoline, locally and internally, in several hundreds of long-standing and severe cases of this intractable and common affliction. I have come to regard this preparation as a standard and almost routine remedy; I seldom care for a post-nasal trouble without prescribing it at the onset, and if I don't it is not long before it comes into use. It is just alkaline enough, just so as to the dialysis—the action locally with exactly the right amount of fluid excretion through the diseased membrane), just enough astringent without drying the parts, and just the right thing in the direct line of reparative work; it sets up tissue building soon after the membrane gets somewhere near its right shape. Many things are employed in catarrh, but I firmly believe that if I was confined to one agent only, that would be glyco-thymoline. For years I used the so-called antiseptic tablets of boric acid, and glycerine, etc., and with good results, but for a long time past, this is thrown aside and the glyco-thymoline takes its place. I use it in about half strength with a Birmingham douche and from twice to four times daily. With this, in bad cases, I give it internally, adding to it, or giving separately, mercuric bichloride, and if done separately the menstruum is compound syrup of stillingia. In presumed syphilitic persons I always do this.

In gastritis, chronic enteritis, vaginitis, gonorrhoea, and in recurring attacks of what too many physicians deem appendicitis, I use this agent freely, and always with good results. As a local application to foul ulcers and especially to hemorrhoids I think this preparation is very good. In the nasty leg ulcers which now and then defy all remedies glyco-thymoline does wonders—it can't do harm any time and I am almost persuaded to give it in all instances. In bronchitis and asthma it is fine; in spasmodic croup it fills the bill nicely; it does well in venereal disorders locally, and in balanitis it stops the trouble at once.—W. R. D. Blackwood, M. D., in *Medical Summary*, December, 1903.

**A NEW TREATMENT FOR WRY-NECK.**—Leonard K. Hirshberg declares that the pathology of torticollis rests entirely upon negation and probability. The probability is in most cases that the kinesthetic centers for the sternocleidomastoid, splenius, trapezius, scaleni, and deep cervical muscles are the points of origin for the various spasms. Another way to express our ignorance is to say that torticollis is due to irritation of the nuclei of the neurons. There are many combinations of the various muscles which are possible in this affection. Individuals with neuropathic relatives or ancestry are more subject to torticollis than the average person. Congenital and rheumatic wry-neck are not included in this paper. The treatment of the first patient reported is given as follows: The faradic current was used for five minutes daily over a period of four months. The positive electrode was placed over the wrist and a roller (negative) electrode was applied over the healthy sternocleidomastoid and upper fasciculus of the trapezius on the unaffected side. Liquor potassii arsenitis was given in doses of two drops three times a day for four months. Almost from the beginning there was marked improvement. At the end of the treatment the patient's head was perfectly erect, and a scarcely perceptible stiffness of the muscles remained. The cosmetic result was excellent, and although the arsenic has been stopped for some time, there had been no return of the clonic spasms. In another case treatment consisted of a rigid diet and the application of the faradic current for five minutes daily to the muscles of the well side. Improvement was steady. In the third case the treatment was the same as in the first, and at the end of three weeks the patient discharged himself as cured.—*Maryland Medical Journal*.

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**DIASTOLIC AORTIC MURMURS WITHOUT VALVULAR LESIONS.**—G. A. Gibson believes with Babcock that there is a form of aortic insufficiency, which although not due to valvular defect, yet presents the same clinical features as the organic form, and is so frequently encountered that it may here be briefly dwelt upon. This is a relative incompetence of the semilunar valve, and its causes are found in conditions that predispose to stretching of the ventricular wall and of the basal ring of the aorta. The writer cites two cases in point. The first patient was a man aged 30 years. He was suffering from chronic nephritis. In the aortic area, a hard systolic murmur was heard, which was propagated into the carotids. The

second sound was impure and was followed by a soft blowing diastolic murmur, best heard over the sternum, and hardly propagated at all. Autopsy revealed a dense band surrounding the aorta and pulmonary artery. This caused considerable displacement as well as constriction. The writer believes that the diastolic murmur was produced, not by stretching of the orifice (which was negatived by the result of the post-mortem examination), but by faulty adaptation of the aortic cusps. The systolic murmur was no doubt largely due to some dilatation of the vessel beyond the constriction. The second patient died of aneurysm of the aorta. About a year before his death a diastolic murmur developed over the upper part of the sternum. In neither case was there any permanent stretching of the orifice. The writer believes that the murmur was due to faulty adaptation of the different cusps of the aortic valve. It is impossible to conceive of temporary dilatation, and in default of any pathological proof of enlargement of the orifice, faulty application of the individual cusps to each other can alone be entertained as the cause of regurgitation.— *Edinburgh Medical Journal*.

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THE WANING GLORY OF THE LEUCOCYTE.—As the chief hero in the contest between the bacterium and the man, the leucocyte seems to be suffering the fate of many another shining light of battle, and its once high position is being most vigorously assailed. At first, the only means of defense against bacteria that had once gained a foothold and begun to multiply, so far as known, was the intrepid leucocyte, which was supposed to attack the most virulent bacteria, engulf them while in full activity and either to digest them or die in the attempt. Through the work of Metchnikoff and his school, particularly, this power of the leucocyte was made familiar to all, and the subject was elaborated vigorously. It was not long, however, before voices were raised in opposition, contending that the leucocyte was not so much of a hero after all, but merely a scavenger that picked up the bodies of dead or crippled bacteria and destroyed them, but was unable to give much protection against bacteria that were virulent. The injury to the bacteria, according to these investigators, was essential for successful phagocytosis, and was accomplished by soluble substances present in the serum which possessed marked bactericidal powers. Thus arose two schools—the humoralists and the supporters of the phagocytic theory.

Naturally enough most of the French pathologists followed Metchnikoff and their work was influenced by his ideas, while the Germans were solidly lined up on the opposite side.

At last the defenders of the leucocyte were forced to recognize the actual fact of the presence of bactericidal substances in normal blood plasma, and they then fell back to the ground that, although the leucocyte could pick up and destroy virulent bacteria, yet they were much better able to accomplish this if the organisms had been previously injured, and that the substances that injured the bacteria were produced and secreted by the leucocytes. Destruction of bacteria, they contended, was the function of leucocytes, which was accomplished either intracellularly after phagocytosis, or extracellularly by bactericidal products of the leucocytes, or by combining the two processes. As a compromise that recognized the potencies of the serum, this view met with considerable favor, particularly as there were many features of immunity that bore it out, and Buchner, Gruber and others were convinced that "alexin," the bactericidal constituent of blood plasma, was a product of the leucocytes and in nature like a proteolytic enzyme. Ehrlich and his school, by showing that the alexin of Buchner really represents two uniting substances, the "complement" and the "intermediary body," made necessary further modification of the leucocyte's part in immunity, which developed in the form of an assumption that the complement, which bears much resemblance to a ferment, was the contribution of the leucocyte, particularly the polymorphonuclear neutrophile.

But even this last shred of honor is threatened, and particularly by the interesting studies of Petrie.\* Using the method of Rowland for obtaining the inmost constituents of cells, which consists of triturating the cells after they have been made brittle by exposure to the temperature of liquid air, he obtained extracts of leucocytes. Although this process does not destroy the bacteriolytic properties of normal serums, the extracts of the leucocytes so obtained were found to be entirely devoid of bactericidal powers, showing that they contained nothing resembling an "alexin." Neither did they contain anything in the shape of a bactericidal "complement," for they could not reactivate the normally bactericidal serum that had been deprived of complement by heating. This was found to be the case with the leucocytes of the normal rabbits when

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\* *Jour. of Path. and Bact.*, 1903, ix, 130.

tried against typhoid bacilli, for which the serum of rabbits is powerfully bactericidal, and the leucocytes of rabbits rendered highly resistant to typhoid bacilli by immunizing were equally devoid of alexin or complement. From these experiments, which are in accord with others performed by different methods, it appears that Metchnikoff's view that the bactericidal substances of blood exist in the bodies of the leucocytes to be liberated on their destruction, cannot be accepted. There remains still the possibility that the leucocytes really do secrete bactericidal substances, but that they do not exist preformed within the cell. In other words, they resemble the inactive zymogens that become active on or after secretion.

In any case, however, there is a strong tendency, based on good grounds, to rob the leucocyte of much of its former significance. Yet it is still to be contended that the leucocytes must have some function, and this is almost certainly connected with the resistance of the body against infection, and even if it does not happen to be just what Metchnikoff thought, yet it is probably of importance, else why the leucocyte?—*Journal of the American Medical Association.*

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INDUCTION OF ANAESTHESIA IN PROSTATIC AND RENAL SURGERY.—Mark, reasoning from the evidence adduced for and against the method of subarachnoid injections of cocaine, believes that the following conclusions are justified: (1) That the method is as safe as, if not safer than, general anaesthesia. (2) That we may safely employ up to 48-100 of a grain of cocaine without fear of toxic effects. (3) That shock, when present, is decidedly less than that of general anaesthesia. (4) That it is attended with less danger of annoying sequelae and symptoms. (5) That on account of the variability in the length of its analgetic action it is contraindicated in prolonged operative procedures.—*Medical and Surgical Monitor.*

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NASAL DISEASE.—The indications for operative treatment depend on both the subjective and objective symptoms. A noticeable inadequacy of either nasal passage, the presence of excessive or retained secretion, or an abnormal redness of the mucous membrane at any point, are all evidences of abnormality, which, if coupled with inconvenience to the patient, invite corrective attention.—Edw. Pynchon, M. D., in *Medical Record.*

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### NYMPHOMANIA.

- R. Liq. potassii arsenitis, ..... m viij.  
Sodii bromidi, ..... 3 iv.  
Aq. camphoræ, ..... q. s. ad fl. 3 viij.  
M. Sig. Tablespoonful in water after meals. — *Ex.*

### PASSIVE CONGESTION OF THE LIVER.

- R. Ext. ergotæ, ..... 3 j.  
Pulv. scillæ, ..... gr. xiv.  
Hydrarg. chl. mitis, ..... 3 ss.  
Pulv. digitalis, ..... gr. xv.  
M. Ft. pil. No. 40. Sig. One pill t. i. d. — *Brommier,*  
*Med. Rec.*

### BURNS.

A saturated solution of potassium permanganate is recommended as an application for burns. It diminishes pain very markedly and causes a rapid healing of the wound. — *Kharitonov Med. Rec.*





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**STRANGURY.**

℞ Chloroform, ..... fl. 3 xij.  
 Pone in phialas, ..... No. xij.  
 Sig. Pour the contents of one phial upon handkerchief and inhale.  
 Indication. — Used to relieve pain and relax spasm of ureter or urethra during passage of calculus. — *Ex.*

**DELIRIUM TREMENS.**

℞ Pulv. jalapæ comp., ..... gr. x.  
 Hydrargyri chloridi mitis,  
 Sodii bicarbonatis, ..... aa gr. v.  
 M. Ft. chart. No. j. Sig. On tongue at once.  
 Indication.—Initial treatment.—*Ex.*

**HYPERIDROSIS OF THE FEET.**

The *Medical Press* recommends the following in hyperidrosis of the feet:

℞ Menthol ..... gr. v.  
 Acidi salicylici  
 Acidi thymi ..... aa gr. xv.  
 Spir. lavendulæ ..... ʒ vj.  
 M. Sig. Wash the parts well, dry, and bathe well with lotion.

As an antiseptic astringent:

℞ Acidi salicylici ..... gr. 15.  
 Sodii biboratis ..... gr. 75.  
 Zinci oxidi  
 Talc. præparatæ ..... aa ʒ iss  
 M. Ft. pulv. Sig. Sponge the parts well and apply the powder.

Or:

℞ Salol  
 Aluminis ..... aa gr. 75.  
 Zinci oxidi ..... ʒ j.  
 Talc. præparatæ ..... ʒ ij.  
 M. Apply locally.—*Jour. A. M. A.*

**DYSMENORRHOEA.**

℞ Amyli nitritis, ..... fl. 3 j.  
 Sig. Five drops upon handkerchief by inhalation to relieve severe pain.  
 Indication. — Used in spasmodic dysmenorrhœa to relieve pain. — *Ex.*





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W. J. Robinson, in *Merck's Archives*, states that when the gums are hot and tense, frequent rubbing with the following combination will give proper relief:—

Potassii bromidi, ..... gr. xx.  
Chloralis, ..... gr. x.  
Tinct. aconiti rad., ..... m v - xxv.  
Spir. chloroformi, ..... 3 j.  
Mucilaginis, ..... q. s. ad 3 j.

M. Sig. Apply to the gums frequently by rubbing.

At the same time he recommends that the following be given internally:—

Pot. bromidi ..... gr. iii - v.  
Chloralis, ..... gr. i - ij.  
Aq. dest., ..... q. s. ad 3 ij.

M. Sig. To be given at one dose by the mouth. The foregoing mixture may be given in double the size dose per rectum, using starch water as a vehicle. — *Ex.*

#### TONIC AFTER SURGICAL OPERATIONS.

Tinct. ferri chloridi,  
Tinct. digitalis, ..... aa 3 v.  
Acid. phosphoric dil., ..... 3 x.  
Glycerini,  
Aq., ..... aa q. s. ad 3 iv.

M. Sig. One teaspoonful in wine-glassful of water after each meal, through a glass tube. — *Vander Veer, Ex.*

#### ASTHMATIC DYSPNOEA.

Dr. Davis, of Chicago, advises the following for asthmatic dyspnoea:—

Chloral, ..... 3 5.  
Sodium nitrate, ..... gr. 45.  
Tinct. stramonium, ..... fl 3 2½.  
Elix. simp., ..... q. s. ad 3 4.

M. Sig. One teaspoonful every four hours in water.  
— *Medical Summary.*

#### SEMINAL EMISSIONS AND GENERAL WEAKNESS.

Tr. Nux Vom. ..... 2 drachms.  
Satyria ..... q. s. 8 ounces.

M. Sig. Teaspoonful four times daily.

#### DIURETIC (Acid Condition).

Satyria ..... 2 ounces.  
Potass. Acet. ..... 2 drachms.

M. Sig. One to two teaspoonfuls three times a day.

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 Aq., ...  
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 Sig. Tl

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**R.** Hydrarg  
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### LEAD COLIC.

Potassii iodidi, ..... ʒ iv.

Aq., ..... q. s. ad fl. ʒ iij.

M. Sig. Teaspoonful in water every four hours.

Indication. — Used to eliminate lead from tissues. — *Ex.*

### ULCERATIVE KERATITIS.

Hydrargyri chloridi mitis (levigated), iv.

Sig. Dust on cornea.

Indications. — In simple ulcers, but must not be used when iodides are given internally. — *Ex.*

### ACUTE TONSILLITIS.

℞ Potassii chloratis ..... gr. xx.

Tinct ferri. chloridi

Glycerini, ..... aa ʒ ss.

Aq. .... q. s. ad ʒ ij.

M. Sig. Apply to the tonsils with cotton swab every two or three hours.—*Stevens, Med. Rev. of Revs.*

### ECZEMA.

℞ Chloralis,

Camphoræ, ..... aa gr. xxx.

Tritura et adde

Ungt., ..... ʒ j.

M. Sig. Apply.

Indications. — Used to relieve itching in subacute, non-exudative eczema. — *Ex.*

### URTICARIA.

℞ Mentholi ..... gr. xv.

Alcoholis

Ætheris ..... aa fl. ʒ i. ss.

Spir. methyli salicylati, ..... fl. ʒ ss.

M. Sig. Apply locally.

Indication. — Used to allay itching. — *Ex.*

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### *Original Communications.*

#### **MEMBRANOUS CROUP — WITH REPORT OF CASES.\***

BY J. T. HERRON, M. D., JACKSON, TENN.

Membranous croup or croupous laryngitis is said (by Shurly) to be identical with laryngeal diphtheria inasmuch as about eighty or ninety per cent. of the cases, show the presence of the Klebs-Loeffler bacillus in the exudate. Sir Morrell Mackenzie believed the two to be identical.

Both diseases affect the mucous membrane, and a false membrane is produced. The larynx is attacked in both. Respiration is interfered with by both. Membranous croup primarily affects the larynx, while diphtheria generally commences in the pharynx, although it may involve the larynx.

Northrup cites one hundred and fifty-one cases of diphtheria. only one case of this number was limited to the larynx, while

\*Read at meeting of Tennessee State Medical Association, April 12, 1904.

eighty-eight involved the pharynx and larynx at the same time.

Bishop (in whose opinion I have great confidence) says he is not prepared to admit their identity. He believes that the wide difference between the unicists and dualists can be harmonized by recognizing what is true pathologically and clinically: that there exist two kinds of membranous croup, one diphtheritic, and the other non-diphtheritic.

The *Medical Record*, Sept. 15, 1894, mentions two hundred and eighty-six cases of membranous croup, eighty per cent. were diphtheritic and fourteen per cent. were not. It seems to me in summing up the opinions of various authors, that the true diagnosis or rather the differential diagnosis between membranous croup and true diphtheria is the difference in their severity, the toxæmic condition of the one over the other.

Membranous croup has for its bacillus the streptococcus longus, streptococcus pyogenes, and the staphylococcus. True diphtheria, on the other hand, has the Klebs-Loeffler bacillus. The latter bacillus is one of great vitality, and after lying dormant for years the disease may be conveyed. Cases are recorded in which infection occurred from clothing, etc., as long as twenty years.

Bishop claims that membranous croup is neither infectious nor contagious. You will notice that in most of my cases, there were two affected in each family. I do not believe for a moment that one of this number had true diphtheria.

CASE NO. 1.—Early in October I was called to see Senter Crook, age four years, son of Dr. Jere L. Crook. He had been quite well until late in the afternoon on the previous day. His symptoms, when first taken and during the night, were those of an ordinary attack of croup.

He was actively treated from the beginning, with little benefit. At 8 o'clock A. M. I made an examination of his larynx. I failed to get a good view, but in attempting to do so, I held the mirror firmly against the fauces, until he had gagged two or three times, and as he did so several pieces of the exudation came up and fell on the mirror.

A positive diagnosis of membranous croup was made. Making the diagnosis this way was entirely new, and incidental, and

I think, unique. I was trying to see the larynx. I am convinced the diagnosis that morning would have been in doubt, had not pieces of newly formed membrane fallen upon my mirror. I have placed some stress upon the above, because it has been of so much value since that time in making the diagnosis of nearly all my cases. This method may be old to many or all of you: if so, nothing is gained; if not, then my advice is to do all you can to make an undoubted diagnosis as soon as possible. If you cannot make a laryngoscopic examination, get some one to do so, if it is so that you can, without too much loss of time.

Two thousand units of antitoxin was given at once. Small doses of calomel were given, also local treatment with spray.

On my return that night he had vomited up particles of membrane. Temperature  $101^{\circ}$ , doubtless from the antitoxin. On examination of his larynx, the membrane could be plainly seen. Two thousand more units of antitoxin were given. A restful and quiet night was spent. Next morning I found him much improved. His recovery was rapid.

CASE NO. 2.—In less than a week Jere L., Jr., age sixteen months, a brother of Senter, took croup. His symptoms were not so clear as Senter's. I could not make an examination with the laryngoscope. He was removed from the room, and not permitted to come in contact with Senter, as soon as a diagnosis was made. We gave him one thousand units of antitoxin, and repeated the dose in less time than twenty-four hours. On the morning of the second day small pieces of membrane were found in his stool. Much doubt existed as to diagnosis at first, yet it proved to be membranous croup with a good recovery.

CASE NO. 3.—October 21st, I was called in consultation by Dr. H. to see J. B., age seven years, to make an examination of his larynx. He had been croupy for several days, and grew worse regardless of treatment. I found him breathing with great difficulty; could be heard some distance from the room.

He had that anxious expression which is always indicative of great danger. Pulse 120. No fever. The membrane could be easily seen, as it had come out of the larynx and almost covered the epiglottis. I gave him at 6 P. M. three thousand units of antitoxin. At twelve o'clock that night his breathing seemed

to be slightly easier. I repeated the same amount — three thousand units. At ten o'clock next A. M., with the laryngoscope, I found the red line had formed around the exudate on the epiglottis. All the symptoms were better.

I gave him two thousand units of antitoxin. At 4 o'clock that afternoon his breathing was better. He stated to his mama before going to sleep that he felt something moving in his throat, and asked her if she could not hear it. We gave him two thousand units of antitoxin. That night at ten o'clock we gave him one thousand units, making eleven thousand units of antitoxin in thirty hours. Morning of 23rd he was much better.

That morning he passed, it seems to me, the entire membrane from his bowel. After a few days he had slight feverish disturbance, pain in his joints, rash on the skin, as a few of the serumtherapy patients have; however, with that exception, his recovery was everything that one could wish.

It may have been after seeing the red line around the exudate, I could have safely stopped the antitoxin at eight thousand units. I recognized the gravity of this case, therefore having confidence in the purity of Mulford's and P. D. & Co.'s antitoxin, I gave it without any fear of bad after results.

CASE NO. 4.— November 9th, I was called to see Mattie L., second child, age three years, with Dr. H. She had been removed and was not allowed to come in contact with her brother since the diagnosis was made. She had had croup about twenty-four hours, and symptoms were those of membranous croup. I could not examine the larynx. We gave two thousand units of antitoxin at 8 P. M. On my return visit next morning we repeated the dose — two thousand units. Her recovery was good.

I immunized the baby, age one year, with seven hundred and fifty units of antitoxin. This was done when I made my first visit to see the little girl.

CASE NO. 5.— I was called, December 4th, in consultation with Dr. R. to see H. C., age seven years. This boy had just recovered from measles. This case was doubtful, and I believe it would have been almost impossible without the aid of the laryngoscope to have made a diagnosis.

I saw the membrane in the larynx. I gagged him and a

deposit of exudation fell upon the mirror. This I showed to the family, as they opposed antitoxin. We gave at 8 p. m. three thousand units of antitoxin. Next morning his symptoms were better. At that time we gave two thousand units, with fine success.

CASE No. 6.—December 12th, just one week after the boy's illness, I was called to see his sister, Mary C., age five years. She was removed from his room when I was first called to see him. She had measles at that time, followed by pneumonia, and before her recovery she took membranous croup. She was critically ill for several days.

I could not examine her larynx, but got a deposit of exudation on the mirror. We gave two thousand units of antitoxin that night, and repeated the dose next morning. Her recovery was slow. I do not see how she could have recovered had it not been for the early dose of antitoxin.

CASE No. 7.—December 10th, I was called in consultation with Dr. R. to see Bessie M., age six years, to examine her larynx. She had measles followed by croup. I found a well-formed membrane encroaching upon the epiglottis. We gave her at once, ten o'clock at night, three thousand units of antitoxin. Next morning her breathing was better. We gave two thousand more units with good results.

CASE No. 8.—Feb. 15, 1904, I was called in consultation with Dr. M., twelve miles from town, to examine the larynx of J. L., age seven years, and ascertain if he had membranous croup, as many symptoms pointed that way. I arrived there at 7 o'clock A. M. After repeated efforts I failed to see his larynx, owing to sick stomach, which he had during the night.

In the examination I secured pieces of exudation on my mirror. I gave three thousand units of antitoxin. Six hours from that time I found him breathing much better. I gave him two thousand more units. He made a good recovery.

I immunized two smaller children, age five and three years. The one five years old had been a little croupy for twenty-four hours. I gave her two thousand units, the other one thousand.

CASE No. 9.—I was called, February 20th, in consultation with Dr. C. to see Rob P., age two years. He had recovered

from measles and took catarrhal pneumonia, and it was thought that he would recover. The night before I was called he took membranous croup. When I arrived I found him in a moribund state, with no hope for recovery. I gave him two thousand units of antitoxin without benefit. He died nine hours after the antitoxin was given. He was in such a condition that it was impossible to intubate.

Statistics show that membranous croup before the use of antitoxin was a very fatal disease, considerably more than one half of the cases dying, sixty or seventy per cent. Since O'Dwyer introduced intubation of the larynx the death rate has greatly improved.

Ranke reported 1,445 cases intubated in Germany for croup, with 553 recoveries, or 38 per cent. O'Dwyer claimed in 1894 that the mortality of laryngeal diphtheria without treatment is 90 per cent., which can be reduced to from 27 to 47 per cent.

The average mortality from diphtheria where antitoxin was used in 1902 was 6.48 per cent. The average mortality from diphtheria where antitoxin was not used in 1902 was 32.5 per cent. The death rate has, therefore, been reduced more than three fourths by the use of antitoxin.

In twenty-five of the largest cities in the United States, aggregating a population of 11,362,060, this means that antitoxin has reduced the mortality of diphtheria over 75 per cent.; in other words, more than seventy-five out of every one hundred recovering from diphtheria owe their lives to the use of antitoxin.

The average mortality from diphtheria where antitoxin was used upon the first day is 1.45 per cent.; second day, 3.9 per cent.; third day, 5.67 per cent.; fourth day, 14.49 per cent.

Rose Engleman, of the Chicago Health Department, in detailing the results of her experience with antitoxin, says seven deaths in 103, or 6.97 per cent., is a very low death rate, especially if one considers that fifty of the 103 cases were membranous croup. I could call your attention to thousands of cases recorded; but it seems to be useless.

I commenced this paper to add a very few cases to that enormous list that have been saved by antitoxin. I firmly believe if antitoxin had not been used two thirds or three fourths

of my cases would have been with the angels. Now gentlemen, it is in our power to lower this death rate. We cannot do it if we depend upon local treatment.

This is necessary as well as to open the secretions; but that is nothing as compared to the serumtherapy treatment.

Give antitoxin, and give it early, and in large doses, do not wait, to-morrow may be too late. I prefer Mulford's because of its easy injection. I have used much of P. D. & Co.'s; both are reliable.

To sum it up, then, we are expected to do three things if necessary in every case of membranous croup: First, give antitoxin; second, intubate; and third, perform tracheotomy. If we give antitoxin and give it early, and in large doses, we will have very little need of intubation or tracheotomy.

What shall we do if we find several children sleeping in the room with a membranous croup case? My future plan shall be to remove them at once and give each one under seven years an immunizing dose of antitoxin.

If this grand and noble body of physicians collected here to-day, had as much zeal and determination to blot out the microbe as Klebs, Loeffler, Roux, Welch, Prudden, and others in discovering it, some day a monument would be erected to your memory by the victors of this much-dreaded disease. We can do it if we will.

If I fail to impress upon this section the importance of prompt administration of the remedy, and in full doses to the point of toleration, a positive diagnosis having been made by the laryngoscope, I shall miss the main point which I intended to convey to you in this paper. An examination of the larynx, except in the very young, is not difficult, and can be easily acquired, that is, a fair working knowledge by little practice, with the laryngoscope, by the physician who makes no pretension to specialism. The laryngoscope will show the deposition of the exudate early in the disease, thus establishing beyond question the diagnosis.

A reference to the above statistical table I have just read you will show that an immediate resort to antitoxin saves the life that would probably have been lost while temporizing and wait-

ing. By your indulgence I shall refer briefly to a case which did not occur in my practice, but in that of a friend.

This child was strong in health previously. The true nature of the disease was not determined until the fourth day when antitoxin was administered, but as death was at that time imminent, the remedy was unavailing.

If in reporting these cases I am influential in causing a more extended use of antitoxin by the profession generally, I shall feel that I have not only been useful to you, but what is more to be desired, I have been instrumental in alleviating human suffering, and saving the lives of our children from this most formidable disease.

My strenuous advocacy of this remedy is based not alone on the use of it in my hands, but the cases in which it is not used, which result fatally, after much suffering, appeal to me, and cause me to try to do what I can to induce others to use it.

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### DIPHTHERIA—WITH A RESUME OF CASES TREATED WITH ANTITOXIN.\*

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BY J. B. WITHERINGTON, M. D., MUNFORD, TENN.

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Diphtheria is an acute, specific, contagious disease due to the bacillus of Klebs-Loeffler.

It is characterized by the formation of a false membrane on the tonsils, pharynx, nose, or larynx, which results in an inflammation of varying intensity and severity from a mild catarrhal condition to a most serious inflammation, and may be followed by local or general paralysis.

Diagnosis: The temperature is moderately elevated, pulse usually rapid, the patient listless, dull, or somnolent; does not complain of any pain; some little sore throat; on examination there is revealed a dusky red or glazed throat, and within this area of redness one or more grayish-white patches of tough membrane, which as the case progresses, changes to a shade of brown, dark green, and sometimes it becomes black. This membrane

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\*Read at meeting of Tennessee State Medical Association, April 12, 1904.



may be situated on the tonsils or may extend to the soft palate, uvula, pharynx, posterior nares, larynx, and even to the bronchi; after a day or two there is emitted a characteristic odor, which as the membrane decomposes becomes foul. If this membrane is detached, the surface bleeds freely, the parotid, submaxillary, and sometimes cervical glands, swell and become prominent, but all cases are not thus well marked. There are many variations; the membrane may be so situated that it can not be seen as when it occurs in the posterior nares or in the larynx. Here general symptoms and surroundings must be our guide. If the patient is a child and there is an epidemic prevailing, this is enough to create suspicion. If the membrane is in the nose, there will be a serous or serosanguinolent discharge. The characteristic symptoms of laryngeal diphtheria are increasing hoarseness, aphonia, and dyspnoea. It is more insidious than croup, and the dyspnoea is continuous, whereas in spasmodic laryngitis the dyspnoea is paroxysmal, coming on at night, and is chiefly inspiratory, while membranous dyspnoea is constant and steadily increasing, and is present both on inspiration and expiration. The voice is not usually lost in catarrhal laryngitis, but in diphtheria of the larynx there is aphonia. There can be little room for doubt, says Holt, when there are enlarged glands, membranous patches on the tonsils, nasal discharge, and albumin in the urine. We, however, rarely ever find all of these symptoms present together, so that it often becomes necessary to appeal to the bacteriological examination of the exudate to settle the question. From follicular tonsillitis it is sometimes difficult to make a diagnosis. The membrane on the tonsils is in patches or tufts, separated from one another, but if they are firmly adherent and disposed to bleed when removed, it is most likely diphtheria. Then in follicular tonsillitis the pulse and temperature preserve their ratio.

The temperature is higher, the eyes bright, cheeks flushed, and more pain in the throat. Then the tendency of the diphtheritic membrane to spread from the tonsils to other parts; but the positive diagnosis can only be made by considering the clinical symptoms in conjunction with a microscopical examination of the exudate.

The Klebs-Loeffler or true diphtheria germ may be associated with others, as the streptococcus, staphylococcus, pneumococcus, etc. Here again we must invoke the aid of the microscope and cultures for a positive diagnosis; but it is not advisable to wait for a microscopical examination; the treatment should be instituted whenever there is a probability that it is diphtheria, and cultures made afterwards. The treatment for diphtheria is antitoxin, and the earlier the better. The dose varies with the location of the membrane and the severity of the case. When the membrane is situated on the tonsil, and when it is seen early, and constitutional symptoms mild, I have found that one thousand units, repeated the following day, is often quite sufficient to effect a cure; but if the membrane is extensive or in the larynx, or if the case is seen late, then two thousand to four thousand, or even six thousand units should be given, and repeated in from six to twelve hours if there is no improvement in the symptoms. During an epidemic that occurred in my practice in 1900, I treated thirty-eight cases with the antitoxin, and my partner, Dr. O. M. Walker, and I have treated since that time twenty-four cases—six cases in 1901, nine cases in 1902, seven cases in 1903, and two cases in 1904—in all sixty-two cases, and I want to emphasize this assertion, that in all my professional life I have never used any remedy for any disease that gave me such uniformly satisfactory results as does antitoxin in the early stages of diphtheria. There are doctors yet who will not use it, but I do not believe there is a doctor anywhere who could witness the magical disappearance of alarming symptoms as I have done and not advocate the remedy. Certainly there is no remedy for any disease, says Holt, that has more testimony in its favor than has antitoxin for diphtheria the world over. We have been called in consultation with other physicians to see four moribund cases to which we gave the remedy, each one of which died in a few hours. The Klebs-Loeffler germ had gotten in its work, so to speak. The patients were already beyond the reach of human aid before the remedy was used. Then, too, we were far out in the country, and did not have an adequate dose at hand, and it was impossible to procure it in time to save the cases, if indeed such a thing were possible. The fifth fatal case was

one of mixed infection, so said Dr. Krause, of Memphis, who made the bacteriological examination, in which the remedy was used late, about the seventh or eighth day. The cervical enlargement in this case was enormous, and the asthenia and general prostration was very marked when the antitoxin was given. This patient died from septic poison.

There was one other death. A boy twelve years old had a rather mild pharyngeal case. Two thousand units of antitoxin was injected into his flank. This was followed by a rather well marked case of urticaria, which gradually gave way, all symptoms of the diphtheria rapidly disappeared, and he was dismissed on the third day, and was up and about soon after. Two weeks later, very suddenly, he took something like a congestive chill and died in about two hours. The death in this case could not have been due to the antitoxin, nor to the diphtheria, as he had seemingly recovered. This is the only case in which the injection of antitoxin was followed by urticaria, and I will pause here to say that we have never had an abscess as a result of its use, or any other untoward symptom referable to the injection of antitoxin.

This epidemic broke out in the autumn of 1900, in a section of country that was rather hilly and broken ; the people were generally poor and the dwellings were primitive and for the most part unsanitary. Within a radius of one mile of the place where the first case occurred there were twenty-eight cases treated by myself, besides several other cases treated by other physicians, all in a family connection.

The sixty-two cases treated by us occurred in twenty-nine families. The clinical diagnosis was confirmed in nine families by the microscope ; in these nine families there were twenty-one cases of the disease. We have treated seven laryngeal cases of our own, all of which recovered. In three of these laryngeal cases we had the microscopist to confirm the clinical diagnosis.

Sequellæ: Paralysis of the muscles of the throat occurred in one case, and paralysis of the lower extremities occurred in four other cases.

The paralytic sequellæ occurred in cases in which the remedy was given late.

It happened that the microscope was not appealed to in any family in which the paralytic sequellæ occurred, and that no two cases of paralysis occurred in the same family, so that in quite a number of cases the diagnosis was confirmed by these sequellæ. The hygienic and prophylactic treatment is very important; plenty of fresh air and thorough ventilation should be rigidly enjoined; the patient should be isolated. When the diagnosis is certain, it is a good rule to give the remaining children of the household an immunizing dose of from 100 to 500 units.

The diet should be nutritious but easily digestible. The local treatment I regard of secondary importance. The parts affected should be kept cleansed with some mild antiseptic. If the nasal cavity is involved, and the patient a child, I use a mild lactic acid or normal salt solution, and pour it into the nostril with a teaspoon as warm as can be borne. I usually give an initial course of calomel and soda, and am in the habit of using a solution of tr. chloride of iron and glycerine every four to six hours, and continue it through convalescence.

The heart must be carefully guarded. When the system is saturated with the toxins and the harm has been done to the tissues, when the heart muscles are weakened and the nervous system and kidneys impaired, it requires something more than antitoxin to restore the patient. In this condition rest is of supreme importance. As a stimulant in this condition I like strychnine; digitalis and alcohol are said to be valuable for this purpose. Tonics should be given throughout convalescence.

*Discussion of the Papers of Drs. Herron and Witherington.*

DR. FRANK TRESTER SMITH, of Chattanooga: *Mr. President:* I have been very much interested in these two excellent papers. One of the points made by Dr. Herron in regard to the diagnosis is of importance; it is something new to me.

He spoke of the administration of large doses of antitoxin, and yet in the cases related, it does not seem to me that he gave large doses. I submit that for a child, two years of age, practically moribund, 2000 units would not be considered a large dose. I have never seen a physician who has regretted giving too large a dose. I have seen some who have regretted that the dose was not large enough; and in laryngeal cases the dose should not be less than 3000 units anyhow, and, for a child six or seven years of age, 3000 units is a comparatively small dose, and that is shown in the paper by the fact that the dose had to

be repeated. I have advocated before this Society upon previous occasions the administration of a large enough dose at the start, so that it should not be repeated. In a laryngeal case, in a child six or seven years old, I would not hesitate to give five, seven, or eight thousand units. We should try to estimate the dose the case requires, give it early, and give only one dose, because you will probably get along in this way with less antitoxin than you would by repeating it two or three times. A case in which the author gave eleven thousand units probably would have gotten along with six or seven thousand units if the initial dose had been large.

I prefer tracheotomy to intubation, when necessary, for the reason that we have to leave these patients, and if the tube is coughed out, the probabilities are the larynx will swell immediately and the child will choke before the physician can get there to reintroduce the tube. This happened in one or two cases at the Johns Hopkins Hospital in Baltimore. The house surgeon was there to reintroduce the tube, but the child died before it could be done. On that account tracheotomy is safer in the great majority of cases. Of course, there are some cases in which we cannot obtain the consent of the parents to resort to tracheotomy, and in those intubation would be justifiable. But on the whole I prefer to do tracheotomy rather than intubation.

DR. J. A. CROOK, of Jackson: I wish to manifest my appreciation of these two papers, and endorse fully the statements therein made.

In reference to the paper by Dr. Herron, the little boy he referred to was my grandson, and I wish to say that I had everything in readiness, whether Dr. Herron had made the diagnosis of croup or not, to give the boy antitoxin. I have seen in the last two years several cases of membranous croup or croupous laryngitis, whatever you choose to call it, in which marked benefit has been noted in from eight to twelve hours after its administration. I have only seen one case that terminated fatally, and this was one in which I was called in consultation, the patient dying about two hours after the antitoxin was administered.

Another point which was brought out, and one I would emphasize, is, if you do not succeed in finding the diphtheritic membrane, when you have a child with evidences of croupous laryngitis, and the case does not yield to ordinary remedies, give antitoxin, and then take all the time you wish to make a correct diagnosis. You have plenty of time to confirm your diagnosis after you give antitoxin. Do not hesitate in any of these cases to use it, for if antitoxin is given early, after the initial symptoms, you will not need such large doses as have been referred to by Dr. Smith.

The only inconvenience I observed was the rash which little Jere, Jr., had some four or five days after the use of the antitoxin. In some respects it looked like the rash of quinine or a nettle rash.

## THE SOUTHERN PRACTITIONER.

It has been my observation that a patient is not made worse by the administration of antitoxin, even though you are not absolutely sure the case is one of membranous croup or true diphtheria. You must expect to see very much improvement until about eight or twelve hours have elapsed after its administration.

DR. WILLIAM SCOTT, of Dickson: I wish to tender my thanks to the physicians for these papers. I consider them as valuable and as interesting as any that have been read before this Association.

We may not have as much diphtheria or membranous croup as we have of other diseases, but we have not anything so formidable to treat as diphtheria. Four years ago I began to use antitoxin in cases of diphtheria, and I have never lost a case in which I have used it.

The only case of diphtheria I lost was one before I began to use it. I have never administered less than two thousand units as an initial dose, with the exception of an immunizing dose, and then I use a thousand units.

As to the size of the dose, referred to by Dr. Smith, and the age of the patient, it has been my experience that young children need larger doses than old ones or adults. They have less opportunity to breathe, the suggestion of fullness in the throat is less; the physical ability to breathe is less than in an older child. We can get better results from local treatment in older children than in the small or young ones. I invariably use antitoxin almost directly after I come in contact with the patient. If I do not use it at once after seeing the patient, I make a microscopical examination as early as possible, and then put the patient on the antitoxin treatment.

I have had patients whose parents would not allow me to use antitoxin. I believe if they had received antitoxin at first they would have recovered.

DR. C. P. FOX, of Greenville: I do not claim any priority in the use of antitoxin in Tennessee; but these papers and this discussion have brought to my mind a paper that I prepared and read in 1896, in which I reported forty-four cases treated with antitoxin in my section of the State, and I cannot help thinking of the different opinions that were expressed at that time in regard to my paper, and the manner in which it was received. I had just returned from New York, where I had attended Dr. Holt's lecture on the use of antitoxin, and I was very much impressed with what he said. He expressed himself as having great confidence in the results from antitoxin. This was in 1895. In September of that year my own child was taken with diphtheria. I tried to obtain antitoxin in Knoxville, but could not get it there. I wired to a party in Chattanooga and he could not find it there, but a friend of mine in New York, whom I telegraphed, sent it to me. The antitoxin was delayed in coming, on account of some washouts in Virginia, and I did not get it for ten days. I fought the case at my own home as best as I could, and I soon found that the child was recovering.

Following the case of diphtheria in my own child, we had quite an epidemic of the disease, and I had an opportunity of testing antitoxin fully, and in the next few months I prepared the paper I have referred to and read it before the East Tennessee Medical Association. I treated forty-four cases, with two deaths. Four were laryngeal cases, and one of the patients who died was a laryngeal case; the other was a pharyngeal case, and was allowed to go along for some time before treatment was instituted. In the laryngeal case I gave one thousand units; it was my first injection; the child was sick nearly a week, and died, I think, in three hours after the injection. The naso-pharyngeal case died of hemorrhage from the nose. In this case the membrane had sloughed off rapidly and the child bled to death from the nose. It was in a moribund condition when I reached it, and the membrane was thrown off by coughing, followed by severe hemorrhage and death. At that time there was not a practitioner in my section of the State who had used antitoxin. I was accused of experimenting with the drug, and you know the criticism that was made of antitoxin by the medical journals, the *Medical Brief* and *Alkaloidal Clinic*. I made no microscopical examination in these cases, as I had not the facilities for so doing, and which most country physicians are unable to do. But I made the diagnoses from the experience I had in the treatment of diphtheria. I was confirmed in my diagnoses by the results, which were perfectly apparent in every case within twenty-four to thirty-six hours after the administration of the antitoxin. Gradually I became less afraid of using antitoxin. I made it a rule not to give less than two thousand units, and I have given as much as seven thousand units in some cases. My remarks have reference to the cases seen in 1896 and 1897. Since that time I have been able to increase the number of cases I have treated up to sixty, and out of that number there were nine laryngeal cases. As I have said, I have only had two deaths in laryngeal cases, and one of the pharyngeal cases.

I noticed that the diagnoses in the cases reported by Dr. Herron were not confirmed by microscopical examination. In the laryngeal cases I treated there was some exudate on the tonsil, which convinced me that I had true croup to deal with. I am not prepared to say that there is no such thing as membranous croup independently of diphtheria. I am very much inclined to believe, however, that if the exudate is examined in all of these cases, the Klebs-Loeffler bacillus can be demonstrated. I am very much pleased and gratified to know that now antitoxin has been so universally accepted by the profession, and that there is so little criticism in my section of the State regarding its use now as compared with former years. I know there are very few practitioners who treat diphtheria now without antitoxin.

DR. J. S. NOWLIN, of Shelbyville: These papers are the very thing we need. They are up-to-date. The authors have recommended a cure for membranous croup and diphtheria. They have given us the practical

method of treating these affections. There are three or four conditions of the throat that give us anxiety. One is a form of spasmodic croup which is the result of indigestion and cold. Its spasmodic action about the throat causes an ugly cough. It frightens the mother. If in these cases we give an emetic or purgative, with quinine in afternoon, and the next afternoon, the condition is usually benefited or entirely relieved.

There are three forms of inflammatory action which take hold of the throat that give us anxiety until we use antitoxin. One is follicular tonsillitis, and when present, the onslaught is very strong; the fever will run high, with difficult breathing, and soreness about the throat in swallowing. It might seem to us that this was a dangerous form of trouble, but usually it is simple and purely a tonsillitis peculiar to the follicular structures, and perhaps involves the parenchyma of the tonsil itself sometimes. But it is soon over. There is no danger in this form. With a little treatment the trouble is soon relieved.

There are two other forms, one in which there is a diphtheritic exudation. It is a necrotic process; the other is membranous croup, which we call a truly inflammatory exudate, the result of a peculiar inflammation of the organized structures. Now, I could take these forms of trouble and point out the differences in each at considerable length, but I do not wish to do so. The point I want to make is a practical one. Many of us are not capable—at least I am not—of making a microscopical examination. It is not convenient to have the microscope at hand frequently, and I think that is so with the great majority of practitioners. The experience of the medical profession has gone on increasing in favor of the use of antitoxin until we know whether the case is one of false membranous croup, as it is termed, or whether it is true diphtheria. In either event, antitoxin is the remedy, and there is practically no danger from its use. I have used it without any bad results. It is true, I have seen rash on the skin as the result of giving in full, continued doses; but there is no danger attached to this skin eruption. It soon passes off, and if you are familiar with it, it will not frighten you. The practical point is, that if we have a case in which we are uncertain as to whether it is diphtheria or not, we are responsible if antitoxin is not given.

DR. LOUIS LE ROY, of Nashville: The idea that there are two types of membranous croup is certainly substantiated by the etiologic findings. The false membrane is simply an evidence of a reaction of the body against a certain intensity of irritant. That intensity of irritant may be typified by the presence of the Klebs-Loeffler bacillus; but in certain instances the streptococcus and possibly some other organisms may produce an irritant of the same type. This will be evidenced by a similar kind of reaction on the part of the body, resulting in the formation of a membrane, the same as would be formed by the irritation of the Klebs-Loeffler bacillus. In these cases, the membrane is not the product of the bacillus, but the product of the body, and the body will



fight back in this manner if it be irritated to a certain degree. There are, then, clinically, a few cases which resemble extremely closely true diphtheria which are caused, not by the Klebs-Loeffler bacillus, but by the streptococcus. These may show some slight points of difference. The greater the reaction, the more marked the line of redness, not quite the ash-colored membrane, still in some cases the points are so slight as not to be recognizable. Often in these pure streptococcus cases the same results are obtained by the injection of antitoxin, so that there is no question but that the previous speakers have been right in their advocacy of the use of antitoxin immediately, and then making the diagnosis afterwards. But the streptococcus infection is nowhere else nearly as contagious or infectious as is the infection of true diphtheria. Therefore, it may be permissible to wait for a microscopic diagnosis before proceeding to immunize the rest of the cases. Unfortunately, immunization is not carried on as it should be. Because of partial doubt in the matter of immunizing, we can afford to wait a day or a day and a half for our diagnosis.

In the line of treatment, I think the speakers are certainly right in advocating immediate and sufficiently large doses of antitoxin.

DR. HERRON (closing the discussion on his part): I wish to thank the members for discussing my paper so freely.

In regard to the administration of large doses of antitoxin, we differ in regard to that. I believe there are certain toxins in the system (we do not know how many), and if we give one large dose of antitoxin it is excreted by the kidneys, and my own opinion is that a dose of three or four thousand units is amply sufficient as the initial dose, followed in a few hours, say six or eight, or possibly ten, by another dose, if necessary, and repeat until you have antagonized the toxins in the child's system.

One of the speakers said that young children tolerated larger doses than the older ones. I believe that is advocated now by many authorities. In my cases the larynx was attacked and not the pharynx. Pharyngeal and nasal troubles were not present; therefore, it is essential to distinguish between the two diseases. They are not similar. The same bacillus, in my opinion, that causes one does not cause the other. (Here the speaker quoted Lennox Browne and S. S. Bishop as authorities to substantiate this point.)

I believe all of the cases cited in Dr. Witherington's paper were true diphtheria, and in cases of true diphtheria one can give larger doses of antitoxin. I said to one of the speakers that I did not have an opportunity of verifying the diagnosis by microscopical examination. There was not a microscopist nearer than Memphis, and I did not have time to have my diagnoses verified by such an examination. When we treat this class of cases, usually we have no time to have microscopical examinations made to verify our diagnoses. In several of the cases I have reported I had to go quite a distance from my town to see them.

I immunized the children because one, age two, was beginning to have some symptoms of the disease, using 2,000 units of antitoxin. To the one a year old I gave 1,000 units as an immunizing dose. The two children had no trouble, and the other recovered.

DR. WITHERINGTON (closing): I do not know that I have anything to say that will be of interest to the Society in closing the discussion. I wish to say, however, it is rather new to me to hear that membranous croup is contagious. I thought it was not considered contagious, and if I should have more than one case of membranous laryngitis in a family, in the absence of a bacteriological examination, I would diagnose diphtheria; and while I believe there is such a thing as a membrane due to the streptococcus, a membrane due to other things than the Klebs-Loeffler bacillus that appears in the larynx, yet streptococcus infection does not yield to antitoxin so readily. In laryngeal diphtheria the constitutional symptoms are not so grave because they do not have time to develop. The membrane develops so rapidly that the child is suffocated before the heart muscles become weakened, and before the nervous system becomes so much overpowered, as in laryngeal diphtheria.

I lean to the opinion that the majority of Dr. Herron's cases must have been due to the Klebs-Loeffler bacillus.

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## LA GRIPPE AND ITS COMPLICATIONS.\*

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BY A. J. SWANEY, M. D., GALLATIN, TENN.

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*Mr. President:* At the suggestion of some professional friends I was induced to write a paper on la grippe. It is rather a singular coincidence, after promising to do so I was attacked with the disease, and have not yet recovered from its effects. This I must offer as an apology for the meagerness of this paper.

Influenza, or la grippe, is a very acute, specific, infectious febrile disease, moderately contagious, sporadic, epidemic, and pandemic, associated with catarrhal inflammation of the mucous membranes, and with disturbance of the nervous centers, often running a short and favorable course, but often attended with many serious complications.

La grippe, while infrequently directly fatal, causes an indirect loss of life, which is appalling chiefly through complications affecting the respiratory, and in advanced life the circulatory

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\* Read at Annual Meeting of the Tennessee State Medical Association, April 12, 1904.

systems. It has been said that la grippe, while relatively less fatal, is absolutely more fatal than cholera. It is altogether probable that extensive epidemics of la grippe have prevailed since the earliest ages. A short study of the annals of the disease proves conclusively the identity of the disease with all its protean manifestations, from the date of the earliest record down to the present. Every now and then in periods of from five or ten years to forty, the disease has been pandemic, and often originating in the far East or Russia, it has invaded Europe, North America, and parts of South America, sometimes spreading over the globe. Up to 1870 fully ninety such pandemics had been recorded during the preceding two or three centuries, twenty-two of which reached this country. In the United States the first appearance was in 1647, and the last pandemic spread from Turkey in 1889 and reached the United States in 1890, leaving epidemics which have gradually lessened in extent and severity. In 1890 and 1893 it was reduced to comparatively few isolated cases, but in 1895-96 and 1897-98 it again assumed epidemic proportions. Since its last introduction in 1890 it has never entirely disappeared from this country, and is, I might say, more common than pneumonia.

That la grippe is a microbic fever has been demonstrated by Pfeiffer, who in 1892 discovered a bacillus in the sputa which is believed to be the specific cause of the disease in man, because it was found in the sputa of all uncomplicated cases of la grippe examined, and the bacillus disappeared with the cessation of the purulent bronchial secretion.

The isolation of the bacillus does not by any means clear up all the difficulties as to its remarkable outbreaks. It is hard to believe the disease is only contagious and not also only air borne. To use an expression familiar to the physicians of the sixteenth and seventeenth centuries, the virus of influenza would seem to cause a fouling of the air or miasma, from which its pandemic outbreaks take their rise. During the prevalence of an epidemic of la grippe all are liable to be affected. Young children are less frequently and less seriously affected than older persons. Aged and infirm persons, those of nervous temperament, and those whose vitality is depressed, are specially liable, but the most

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robust health does not give immunity. Relapses of the disease are common. The susceptibility of the system during or immediately after an attack is extraordinary, and slight exposure or exertion may induce grave complications. La grippe is a perilous complication of pulmonary consumption. It has the property of picking out the weak points in an individual's constitution, and to this is due largely the indirect fatality of the disease.

The symptoms of the disease taken altogether are somewhat as follows: The patient is chilly and perhaps shivers, presently headache occurs, and a sense of tightness across the forehead in the situation of the frontal sinuses, the eyes become tender, and painful points in the nape of the neck, small of the back, knees, and along the margin of the ribs, with a temperature from  $101^{\circ}$  to  $104^{\circ}$ . The skin is hot and dry; in the catarrhal form there is sometimes hoarseness and a dry, distressing, obstinate cough. There is loss of appetite, constipation of the bowels, or there may be diarrhoea. The debility which comes on at the very outset of the complaint is one of its most singular phenomena, taking place in some cases almost instantly, and in a much greater degree than would seem proportioned to the other symptoms of the malady which it thus ushers in. This rapid and remarkable prostration of strength is the most essential part of the disorder in some cases. This has been recognized by the earliest writers in their record of the disease.

It is a common occurrence to see a strong man recovering from the disease, break out in a profuse perspiration, and feel utterly exhausted and out of breath in attempting to make any ordinary exertion. There are many grades of the disease, ranging from the mildest in which the patient does not take his bed, to the severest in which the patient is prostrated and takes his bed almost helpless in the very beginning of the attack. Various types of the disease present themselves; viz., the catarrhal, the nervous, and gastro-intestinal types.

The catarrhal type begins with chilliness and fever, temperature frequently running up to  $104^{\circ}$ , sore throat and pain on swallowing, a hoarse voice with a persistent hacking cough that

is worse at night, sensitiveness to cold draughts, and a tendency to bronchitis and pneumonia develops.

The nervous type is characterized by intense headache and extreme prostration. There is often so much pain in the muscles that it is difficult to find a position of ease and the patient gets nervous and depressed, even after convalescence there is a marked tendency to neuritis.

The gastro-intestinal type is known by such symptoms besides fever as vomiting, severe diarrhoea, abdominal cramps, and tenderness with intense colic, which may resemble peritonitis. Now it is not to be presumed that we can draw the distinction of each type in all cases, as the symptoms of all are blended in one case, and all that can be said is that the symptoms of one type predominate, added to the general symptoms common to all.

The complications of la grippe are far more dangerous than the disease itself, and to these we must attribute mostly its fatality. From these complications of la grippe I have seen patients die with bronchitis, pneumonia, pleuritis, and heart failure. The most frequent complications are those connected with the respiratory organs. Bronchial catarrh is regarded as one of the symptoms, but there is a marked tendency to bronchitis and pneumonia in many cases, and was pre-eminently so when the epidemic of 1890 was here. Aged and infirm individuals were especially the victims of capillary bronchitis and pneumonia. In all cases of la grippe in old persons a careful examination of the lungs should be made at every visit of the physician. Insidious attacks of pneumonia in old persons are common, and the depression and prostration which sometimes follows such an attack is simply appalling. Complications of the respiratory organs in la grippe often hasten the development of pulmonary consumption. Frequently after recovering the patient is left with a harassing cough which persists for months. Peri-neuritis is a very common complication of la grippe, and by this cause much of the suffering may be explained. Even after recovery patients are left with headaches, neuralgias, etc.

In the gastro-intestinal form of the disease, after a subsidence of the acute symptoms, a chronic gastro-intestinal catarrh

may persist with impairment of nutrition which may prove rebellious to treatment. One attack of la grippe does not secure immunity against a recurrence or return of the disease.

The treatment of la grippe must be governed by common-sense principles, keeping in mind that it is a disease of debility. There is no specific for this strange malady, and our treatment must be expectant, palliative, and symptomatic, yet we can do much to aid our patient to recovery, to assuage his suffering, and to prevent or control complications. To struggle against the disease is supreme folly on the part of a person attacked by la grippe. On the contrary, he shall confine himself strictly to his room, avoid all draughts of air, or better take his bed, especially should he go to bed if he has a temperature of 102° to 104°. Many fatal cases may be traced to the neglect of this rule. The diet should be liquid and bland. A laxative dose of calomel may be given, never purgatives of any kind. The fever should be treated with spirits mindereri, 1 drachm; tinc. aconite, 1 drop, every two hours. Phenacetine, acetanilid, antipyrine, and other coal-tar derivatives are recommended by the highest medical authorities, but I must protest against their use in la grippe, especially among the old and infirm. I am satisfied serious results have happened by the use of these drugs. If given at all, their effects should be closely watched. Pain and restlessness should be quieted by codeine, Dover's powders, or morphine.

For the cough and catarrh of the respiratory organs I would give,

℞ Muriate Ammonia  
Carbonate Ammonia..... aa Grs. V.  
Syrup Senega..... gtt VI  
Liquor Strychnia..... gtt V  
Syrup Tolu..... q. s. ad 3 j

To be given every four hours.

And should bronchitis and pneumonia develop I know of nothing better than the above formula coupled with alcoholic stimulants, counter-irritation, and a nutritious diet.

Gastro-intestinal affection should be met by absolute rest in bed, simple liquid and easily digested diet, oxalate cerium, subnit. bismuth, and opiates.

We must remember that la grippe is an extremely debilitating affection and leaves the patient exhausted in body and depressed in mind, and that a relapse may occur, and that undue exposure may bring serious results. Of this our patient should be warned.

In conclusion allow me again to say our treatment must be based upon common-sense principles, and the physician must rely on his own discretion in the management of his cases.

*Discussion on the Paper of Dr. Swaney.*

DR. T. J. HAPPELL, of Trenton: *Mr. President:* Without consuming too much time, I desire simply to add a few words to what is to me an intensely practical paper, upon the nervous type of this disease, and base it upon an experience which I have had during the past winter.

The author of the paper has referred to some of the minor features of la grippe that are developed which affect the nervous system. It has been my experience this past winter to meet with something more than neuritis, aching, and severe pains throughout the body. I saw in one family two well-marked cases of la grippe in which, after progressing as these cases do ordinarily, and as described in the paper, there were pains in the head which began to increase in severity. Mental hebetude developed, and as the physician in attendance suspected something more serious than he had had in any of his cases, he telephoned me to come out to see them with him. He told me he believed he had two cases of meningitis. I found the mother in bed with evidences of commencing meningitis; also a little boy, six or eight years of age, in whom meningitis had existed two or three days. The child had been conscious up to two days before I saw it. These cases went along with a gradual increase of the symptoms of meningitis, but with apparently no involvement of the membranes of the spinal cord. One of them lived about two weeks; the other died in a short time. We were not surprised at the results in these cases.

Shortly thereafter in my own practice there occurred a case of la grippe in a boy, six years old, who developed catarrhal symptoms, with gradually increasing bronchitis. The mother called my attention one morning, after two weeks' attention to the child, to the fact that the child's neck was stiff. I examined the child's neck and found she was correct. There was stiffening of the muscles of the neck. The boy said he felt well. There was no mental disturbance. In that case, in spite of everything that could be done, the stiffness of the muscles of the neck increased and extended, involving the muscles of the lower extremities, the case presenting a condition the opposite of that found in the other. The mind was clear all the while. The membranes of the brain were not involved; but we had the same result in that case we had in the other, namely, death from spinal meningitis.

I do not know how many of you may have had similar cases as complications of la grippe, and I report them to bring out some discussion.

I differ with the author of the paper as regards treatment, and I have adopted in ordinary cases of la grippe almost a set formula, which comes nearer giving relief than anything I have ever used, namely, a combination of quinine, phenacetine or acetanilid, and salol, equal parts, usually about two grains of each, combining with it camphor, or if there is much nervous disturbance, nux vomica. I rarely resort to any form of opiate to give relief. I have used a few times heroin, guaiacol, and terpin hydrate. I regard that as a typical combination for relief if it be necessary to resort to anything of that kind. In my experience, there is no remedy in the world that will restore these cases to strength more rapidly than to follow them up with preparations of cod-liver oil. We hardly ever have occasion to prescribe cod-liver oil because the patients go to the drug stores, buy it, and take it on their own responsibility.

DR. LOUIS LE ROY, of Nashville: In referring to the complications, I desire to report one case which was interesting to me. The patient contracted an ordinary attack of la grippe of five days' duration, went on toward recovery fairly well, but developed in both knees arthritis, with considerable effusion, and a good deal of pain. This was treated by local applications of tincture of iodine and bandage, and two days after that the arthritis began to subside, when a marked cardiac murmur developed, a systolic murmur, which developed into a mitral. This went on with additional symptoms for four or five days, and subsequently subsided.

While cases of that kind have been reported, still cases of endocarditis following la grippe are not very numerous. Had I not simply stumbled upon this case, the case might have gone on unobserved, because after the arthritis no special symptoms referable to the circulation were observed; but the murmur I know was not there until the time I mentioned, and developed recently, but now is subsiding somewhat.

DR. J. J. WALLER, of Oliver Springs: I wish to speak from personal experience of one phase of the subject presented, and that is the nervous type. I have been the victim of that myself as the sequela of la grippe. It left a neuritis of the musculo-spiral nerve of my right arm. It caused me considerable trouble, and the treatment that did me the most good was aspirin and tonic doses of strychnia.

DR. O. J. PORTER, of Columbia: I do not want to make a report of all the complications of this protean disease which seems to have an unlimited number of complications. I would like to report one of the complications observed in two cases in an epidemic. The cases ran the typical course of five days; fever had subsided, when suddenly fever began to rise, followed by inflammation and pain of the testis. The case ran a course of eight or ten days, with high fever, ended in resolution, but without suppuration. Some physicians have doubted whether this was a complication of la grippe, and I did not care to report the



case until another physician reported one which was a parallel to mine. I am confident that it was a complication of la grippe. There was at no time any tendency to suppuration. The temperature one evening ran to  $105\frac{1}{2}^{\circ}$ . The other case reported before one of our local medical societies was a parallel to mine. The patient had never had gonorrhea and there was no evidence of it at the time the disease developed. Besides, it did not run the course of a typical case of gonorrhea in its action, which involves the testicular structures.

DR. E. A. COBLEIGH, of Chattanooga: I want to specially speak of one of these complications of la grippe that has been mentioned by Dr. Le Roy, namely, cardiac involvement. It has been my experience to run across five grave and most serious cases of such complication of la grippe among a number of lighter grade. One of the patients—a member of this Society—has been an invalid, in one sense, by the disability following profound heart involvement, primarily. Cardiac involvement was early and the main feature of his case, persisting for nine or ten consecutive weeks, and threatening his very existence. While there was perfect recovery from the heart lesion, there was involvement of the lower spine and neuritis of the lower extremities, and to this day the doctor is invalided though able to follow his profession as usual.

Another case occurred to me at the same time, also a physician in practice in this place. While recovering almost perfectly from la grippe, he is to-day (in the State of Texas, where he is with relatives) continuing with a cardiac lesion, two years after the attack. In this case there was developed the most peculiar manifestation of la grippe that I ever saw. He had tonic spasms, at intervals, of the diaphragm and thoracic muscles, and seemed immediately threatened with death from prolonged suspension of respiration, lasting apparently for a minute or more, but probably less than that, though extremely distressing to witness while it continued, and alarming the patient very profoundly. Several physicians saw the case with me, and regarded a fatal termination inevitable, from these paroxysms. But the doctor recovered, got on his feet, and resumed his practice. Four months later acute rheumatism developed and progressed to involvement of the articulations generally, though no sign of rheumatic toxæmia manifested itself when the heart showed its primal involvement. He carries his mitral lesion to-day, and it will abide with him as long as he lives, and he is disabled from active life and in present retirement at this time, therefrom.

The other cases all recovered, although one of them developed a temporary mental aberration which lasted for two or three weeks.

In the light of my experience with these cases, I want to direct the attention of the physician to the point that these complications of la grippe can be more frequently detected if they are more often looked for. Whenever I have a heart that is almost too weak to act, pulse thready and irregular or very slow, it is my habit to interrogate the heart itself; and I believe we will find, if we do this more habitually,

more frequent involvement of the cardiac structures than is generally recognized to be the case at the present time.

DR. DEERING J. ROBERTS, of Nashville: This paper with its graphic description of the disease I regard as a crystallized gem. I take issue, however, with the author of the paper in saying that there is no specific for it. My observations from 1890 up to this day have convinced me beyond question that the alkaloids of cinchona, given to the development of chinchonism, is as lethal to the bacillus of Pfeiffer as it is to that of Laveran. I have used it continuously from 1890 until the present day, and I have yet to see a serious complication of the case where the patient would take quinine freely and early. The alkaloid quinine, taken for two consecutive days, has been followed by no material disturbance; but there has been immediate convalescence, because it acts, as I have seen it do time and again, so satisfactorily that convalescence was assured in forty-eight hours. I have had no cases of rheumatism or of heart complications following its administration. I have had absolutely no patients with crippled hearts following its use. I have had patients to whom I have given it with marked indications of Bright's disease; but I have yet to see a single case in which I found it, as determined by results, contraindicated. I regard it as much a specific for the disease under discussion as it is for malarial fever. I have had fewer failures, fewer cases of retardation of convalescence, fewer lingering cases of la grippe under the full use of quinine than I have of malaria. If you do not give me another drug in the whole armamentarium, I can say to you, I can treat my cases satisfactorily to me with quinine. I grant you that it is a drug which upsets the nervous system, but not to the extent that the poison of la grippe does. Twelve hours after administration, the vegetable alkaloids are eliminated, and the patient is on the road to recovery. I have tried it in case after case, and the only troublesome cases I have had have been those who claimed they had an idiosyncrasy and could not take quinine.

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## IRREGULAR MENSTRUATION AND TREATMENT.

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BY E. C. WILLEY, M. D., OF LOUISVILLE, KY.

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Practitioners of medicine are consulted by no class of patients who display greater solicitude than those who have amenorrhea.

In the popular mind failure of the menses to appear is supposed to be due either to pregnancy or tuberculosis, and either may cause a degree of anxiety that is truly intense.

The term amenorrhea is used to mean the total absence of the menstrual discharge, or a marked deficiency in the quantity of the

flow. Amenorrhea may be physiological or pathological. During pregnancy the absence of the menstrual discharge is, of course, physiological, and demands no consideration in this article. When pathological, the causes of amenorrhea may be said in general to be due to the following:—

(1) Taking cold at or near the menstrual epoch. (2) Severe mental perturbation, as fright, sorrow, or great elation of spirit. (3) It may be symptomatic in several affections, as tuberculosis, anaemia, chlorosis, syphilis, typhoid fever, nephritis, pelvic peritonitis, and other morbid conditions. (4) Obesity. (5) Luxurious life, or overtaxing the nervous system. (6) Stenosis or atresia of the cervical canal, or imperfect development of the tubes, ovaries, or uterus. (7) Vicarious menstruation may make the condition obscure, there being a discharge at the regular monthly periods from the nose, lungs, bladder, stomach, nipple, or other parts.

The treatment of amenorrhea must comprehend attention to general considerations, and special indications must be remembered in the various expressions of amenorrhea.

The treatment must, in a word, comprehend remedies and measures which are indicated by the etiological factors present in every case which comes up for treatment. When the amenorrhea is caused by having contracted cold, the patient should have a warm sitz bath, and hot applications should be applied to the abdomen and thighs. Often a hot vaginal injection will serve a most useful purpose, and a laxative, preferably a saline, will greatly aid in bringing on the flow.

In amenorrhea, delayed menstruation, and dysmenorrhea, Ergoapiol (Smith), has acted in my hands in a most satisfactory manner. In scanty menstruation, I found it particularly valuable, and I shall enter in detail about one of a series of cases of this character, later on in this article, where this agent brought on a full menstruation, and the general health of the patient began to improve at once. When mental perturbation is a factor in these cases, it is manifestly the duty of the physician to have the environments of the patient made as quiet as possible, and anti-spasmodic or nerve sedatives should be added to the treatment.

When amenorrhea is associated with syphilis, the uric acid diathesis, or morbid condition, must receive correct treatment. My experience with Ergoapiol (Smith), is such that I regard it as an indispensable remedy in all expressions of amenorrhea along with proper remedies for any diseased condition associated in the causation of the affection. Of course those cases where the amenorrhea is due to atresia of the cervical canal, and to any other condition which is remedial only by surgical means, drugs will prove of no avail. The same can be said of instances in the amenorrhea due to a rudimentary state of the female organs of reproduction.

A lady some time ago brought her daughter to my office for treatment of amenorrhea. The girl was eighteen years old, and was visibly anæmic. She had an indifferent appetite, and was more or less dispirited. She had enough menstrual flow each month to stain the napkin, but this was all that could be said. I had this patient to take ergoapiol (Smith), one capsule after each meal, and on going to bed, regularly for a month. At the next menstrual period the discharge was without pain and free, and the quantity and color was as natural as she had ever known her menstruation to be. She took Ergoapiol (Smith) in the same way another month, and then ceased to have any further trouble. Her color is good, and her appetite is likewise excellent; she is full of spirit, and, in a word, well.

A lady aged thirty-three had scanty menstruation which had covered the period of a year. At no time in the year had her menstrual period been longer than eighteen hours, but generally twelve hours told the tale. Her menses were not only scanty, but the color of the menstrual blood was pale, and this was attended with a disagreeable odor. This woman had no associated disease that most searching examination could bring out. Still she had steadily increased in flesh for the last two years, and to this I attributed the amenorrhea.

I had this patient to take systematic exercise and a dietary that was rational, and to take ergoapiol (Smith) with regularity, a capsule four times a day. After two months this woman ceased to take the remedy, her menstruation having become normal.

A girl twenty years old was sent to me by the matron of a boarding school. She enjoyed good health prior to entering the school, but for the past three months she had not menstruated, and was suffering constantly with vertigo and had attacks of hysteria. I attributed the amenorrhœa to change of conditions of life — that of an open life on a farm to that of a shut-in inactive life. Ergoapiol (Smith) was given after each meal for two weeks prior to the day of her usual menstruation. This brought her menses on fully. She has since had no further trouble in this way.

Mrs. A. P. L., aged thirty-five. This lady suffered with frequent attacks of headache, had backaches nearly all the time, and suffered greatly with vertigo. She was the mother of three children, the youngest being six years old. For the past four years she had constantly had scanty menstruation and the blood was very pale. She rarely had the menstrual flow to continue longer than fifteen hours. I was satisfied that the vertigo and all her distress was due to insufficient menstrual flow, and I accordingly put her on ergoapiol (Smith). She took it through the month, one capsule after each meal; but for a week before the expected period she took two capsules instead of one. She was greatly pleased this time to have a full and free menstruation. Acting on my advice, she took the capsules three times daily for two months, and this acted in a happy manner and she has now passed the entire year, and has not failed to menstruate freely.

My diagnosis was fully confirmed by this woman's health being good in every way since the establishment of menses on a basis of health.

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MUMPS.— What is believed to be the specific cause of mumps has been isolated by Dr. Samuel Darling, resident pathologist of the city hospital, Baltimore, Md. Working with Dr. William R. Stokes, professor of pathology at the College of Physicians and Surgeons, Dr. Darling has demonstrated the presence of a diplococcus which, in the opinion of a number of Baltimore physicians, may be regarded as the germ of mumps.— *Ex.*

## *Records, Recollections and Reminiscences.*

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### SEVENTH ANNUAL MEETING OF THE ASSOCIATION OF MEDICAL OFFICERS OF THE ARMY AND NAVY OF THE CONFEDERACY.

Owing to the necessity of having to complete the matter for the July number of this journal so soon after the greatest, the most satisfactory, and the most enjoyable of all the reunions of the United Confederate Veterans, we will only be able to give a brief synopsis or summary of the meetings of the Association of Medical Officers of the Army and Navy of the Confederacy. However, in our August number, Mrs. Bonwell, the very efficient and capable stenographer supplied the Association by the Nashville Academy of Medicine, having then had time to fully complete her notes of the meetings, we will commence with a full and detailed report of the proceedings of the meetings, which will be continued in successive numbers, together with the papers, essays, and addresses until another years' record of these Recollections and Reminiscences are completed. Suffice it to say, in this connection, however, that the members of this Association passed some most enjoyable and delightful hours.

The splendid lecture hall on the ground floor of the Medical Department of the University of Tennessee which was most cheerfully tendered by its Faculty, served most admirably in which to hold the meetings; and the beautiful, well lighted, and commodious microscopical laboratory on the floor above, with its windows overlooking both to the south and west, the gaily decorated Broad Street was all that could be desired for the very elaborate, appetizing, but by no means microscopical luncheon served each of the three days by the willing members from the chapters of the Daughters of the Confederacy located in Nashville. The more solid and substantial part of the luncheon, such as cold boiled ham, barbecue, coffee, bread, and pickles were sent up each day from the now famous *Confederate Hotel*, only two blocks away; while the lighter relishes, such as salads, cheese, crackers, cakes, ice cream, sherbet, etc., were supplied by

contract with an efficient caterer, and all arranged and served with most graceful delight by the charming corps of ladies in attendance each day.

The Association was called to order promptly at 10 o'clock on Tuesday morning, by Dr. Geo. H. Price, one of the bright lights in the faculty of the Vanderbilt University, Medical Department, who was the Chairman of the Committee of Arrangements selected by the Nashville Academy of Medicine.

Dr. J. Bunyan Stephens, one of the founders of the Medical Department of the University of Tennessee, now an Emaritus Professor of the branch he taught so successfully and for so many years in this school, and who has for more than a third of a century filled the pulpit of the Primitive Baptist Church, which up to the completion of the first year of our great war had been filled by Jno. M. Watson, M. D., L. L. D., so well and widely known in his day, opened the exercises with prayer.

Addresses of welcome were delivered by Rev. J. H. McNeilly and Hon. Jno. H. De Witt, the former being the pastor of Glen Leven Church, who during the four years of terrible strife, as a chaplain in Quarles' Tennessee Brigade did as much effective work with the sick and wounded as any medical officer of the Confederate States' Army; ministering to the physical as well as spiritual needs of his command. Mr. De Witt is a son of the late Rev. Dr. De Witt, who recently died in this city, and who was also a beloved, faithful, and efficient army chaplain, his son John being one of the most eloquent and talented young members of the Nashville Bar, and Commander of Jos. E. Johnston Camp of Sons of Veterans.

The response to the addresses of welcome was made by Jno. C. W. Steger, M. D., of Gurley, Alabama, who entered the Confederate service at the beginning of the war as assistant surgeon, and surrendered at Gainesville, Ala., May 14, 1865, with the rank of surgeon.

Dr. Price then introduced Dr. Jno. R. Gildersleeve, the President of the Association, who delivered his annual address which will appear in a subsequent issue of this journal. This address was historical in its nature, dealing with the work done in Chimborazo Hospital, the largest at Richmond during the war, through

## THE SOUTHERN PRACTITIONER.

portals passed 76,000 sick and wounded Confederate

otion of Dr. J. B. Cowan, the president's address was filed away in the archives of the Confederacy in New and a rising vote of thanks was tendered Dr. Gilder for the valuable historical paper.

: 30 o'clock the Association adjourned and the members ved luncheon in order that they might attend the general of veterans at the Tabernacle, about two blocks distant.

sequent meetings of the Association interesting papers esented by Jas. Patrick Moore, M. D., of Yazoo City, red in both field and hospital as surgeon; C. H. Tebault, of New Orleans, La., Surgeon-General U. C. V.; S. C.

M. D., of Holly Springs, Miss.; C. L. Hegar, M. D., lville, Miss.; Augustus A. Lyon, M. D., of Nashville, who served 'as surgeon with Lee's Army in Virginia; resting talks or reminiscences made up of anecdotes,

experiences, etc., were made by Dr. J. M. Keller, of ings, Ark.; J. S. Cain, M. D., of Nashville; Dr. A. P.

ow of Lebanon, Indiana, who saw service with the Army ern Virginia; J. B. Cowan, M. D., of Tullahoma, Tenn.,

s, Forrest's chief surgeon and medical director; T. R. M. D., of Trezevant, Tenn., who was senior surgeon of

igade, Jackson's Division, and surrendered at Gainsville, y, 1865 ; Dr. J. C. Chikless, of Beech Grove, Tenn.; Ed.

M. D., of Milledgeville, Ga., who was appointed assist- eon at Montgomery, Ala., 1861, surrendered as surgeon

nattox C. H., Va., April 9, 1865. He received his pro- rank of surgeon on the battlefield at the Second Manas-

is one of the most regular attendants at the meetings ssociation. Other members took part in the discussions

niscences, but it will all appear later when the stenogra- port is completed, which necessarily requires time, hence

ers must be content for the present with this brief and te summary.

D. Plunkett was appointed to confer by mail with the mbers of the Association who were not able to be present



in regard to an Association button to be copyrighted and worn by the members.

The following officers were elected:—

Dr. Jno. S. Cain, of Nashville, Tenn., President.

Dr. J. D. Plunket, of Nashville, Tenn., First Vice-President.

Dr. D. H. Key, of Monroe, La., Second Vice-President.

Dr. Wm. Martin, of Kingston, Ky., Third Vice-President.

Dr. Peter Brockington Bocat, of Florence, S. C., Fourth Vice-President.

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## *Editorial.*

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### THE AMERICAN MEDICAL ASSOCIATION.

The recent meeting at Atlantic City was a most unqualified success in every possible way. The general sessions, the House of Delegates work, and especially that in the sections, together with the attendance was far ahead of any preceding meeting. If some of its founders could *only* have been there to see the results, their child that had now attained on reaching the magnificent stature of a well-grown manhood, they could have well exclaimed with united and unanimous voice, "*Our mantles have fallen on most worthy shoulders.*"

From the delegates from this city, and members, some of whom have been regular and constant visitors to its annual meetings for many years, we get nothing but the most glowing accounts; among them are included three vice-presidents, one representing surgery, another practice, and the other a most important specialty. Others from this city, whose work and inclinations led them to other important sessions, join with one accord in universal commendation in the highest terms. Their statements, together with a somewhat hurried scanning of the pages of the Association Journal's magnificent issue of June 18th, leave no doubt in our minds but that the Association, now working along correct and logical lines, will soon succeed in having the medical profession in this grand country of ours, from one extremity to the other—from East to West—from North to South—keeping step, and well in the vanguard of *Progress and Advancement*.

But we will let the secretary and editor of *The Journal* in his first editorial of the issue of June 18th, make his statement, which is substantiated in every particular by all of our friends whom we have talked with and who were so fortunate as to be there. We give the article in full, as some of our readers have not yet seen the necessity of being

regular subscribers to the *Association Journal*, the best of its kind in the world. It is as follows:—

“The fifty-fifth annual session of the American Medical Association, held last week, was the most successful of any held in the history of the Association, not only in the number in attendance, but in the scientific work accomplished.

“The attendance excelled that expected by the most hopeful. With the exception of one of the international medical congresses, it was probably the largest gathering of medical men ever held anywhere, the registration numbering 2,890. At the meeting in Atlantic City in 1900, 2,019 registered; at St. Paul in 1901, 1,806; at Saratoga Springs in 1902, 1,425; and at New Orleans in 1903, 2,006. Yet in spite of the number in attendance there was no evidence of crowding and no criticism in regard to accommodations. Atlantic City certainly proved herself capable of entertaining in a most satisfactory manner. The local committees of arrangement had done their work well, and are to be congratulated on the arrangements made and on the successful outcome of this magnificent meeting.

“From a scientific point of view, no meeting ever surpassed it, whether we consider the meetings of special societies, international congresses, or what not. Every year some sections report having done very superior scientific work. This year from all sections comes this report. It is not only the section officers and those especially interested in the sections who are saying this, but those who have never before taken an interest in the sections, and who are more directly interested in other societies than in the sections of the American Medical Association, are also acknowledging the superior scientific work at Atlantic City. The section officers deserve great credit for this result of their years' efforts. The officers of each section have vied with each other in trying to outdo what has been done in the past, and to produce a program that should be superior scientifically to that of any preceding year, and to that of any other special society. Those who know the amount of labor necessary to get up such a program and to make a section successful, will appreciate that all the section officers have worked hard and have done their duty faithfully. They have all set standards for their successors that will be hard to surpass.

“The symposia following the orations on Tuesday, Wednesday, and Thursday evenings were something entirely new with this session, and they proved to be valuable as well as attractive. Never before have the general meetings been so well attended. The symposium on the first evening, which was devoted to a description of the research work that is being done in several institutions in this country, was a revelation to those who did not know how much of this work was being done. The symposium on Wednesday evening, on the relation of the medical services of the government to the profession, was also most interesting and instructive.

Such a symposium tends to bring the profession and the services together as nothing else can. We all realize, to a certain extent at least, what the U. S. Public Health and Marine Hospital Service, and the Medical Department of the Army have done and are doing, but we have been very unfamiliar with the work of the Medical Department of the Navy. Surgeon Stokes, in his part of the symposium, showed that the medical officer of the Navy has a wider field of usefulness than is usually supposed. The last symposium, that of Thursday evening, was also valuable and instructive, and brought to the attention of the profession other work that is being done by the government that is of special interest to medical men. While the building in which these meetings were held was a large one, standing room was at a premium on each occasion. President Musser deserves the thanks of the profession for having arranged for these symposia, and those who took part in them are also entitled to thanks for what they did to make them so successful."

The following officers were elected to carry on the good work during the ensuing year:—

PRESIDENT—Lewis S. McMurtry, Louisville, Ky.

VICE-PRESIDENTS—Edward Jackson, Denver; James Hall Bell, San Antonio, Texas; F. C. Shattuck, Boston; B. C. Penington, Atlantic City.

SECRETARY—George H. Simmons, Chicago.

TREASURER—Frank Billings, Chicago.

TRUSTEES—T. J. Happel, Trenton, Tenn.; W. W. Grant, Denver; Philip Marvel, Atlantic City.

PLACE OF MEETING—Portland, Oregon.

ORATION ON MEDICINE—Charles G. Stockton, Buffalo, N. Y.

ORATION ON SURGERY—John Collins Warren, Boston.

ORATION ON STATE MEDICINE—George Blumer, San Francisco.

Good men and most competent—true and tried,—and we know will prove most worthy.

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#### DIPHTHERIA AND SERUM-THERAPY.

In our "Original Department" this month, we have given place to two most valuable papers and the discussions thereon, a part of the valuable *outcrop* of the last session of the Tennessee State Medical Association. Although this dread disease is more prevalent in the winter and spring months, in the lull, or just after the battle, is the best time to prepare and make ready for the next onslaught of the enemy. We can then better take stock and prepare our means of defense against his ravages. There are yet able and experienced members of the profession who have not yet subscribed to organo-therapy in any form; and then there a large number of the readers of this journal who will not have access to the Transactions of our State Association.

Upon the subject of the early antitoxin treatment of diphtheria, the views presented coincide with those of the leading teachers of medicine

in this country and Great Britain; and we feel it our duty to aid in disseminating certain truths which are unassailably sound and correct, but which have by no means the vogue that they deserve.

McCollon, of Boston (*Boston Medical and Surgical Journal*, Dec. 25, 1900), expressed the opinion three years ago that "small doses are of little avail in the treatment of grave types of the disease:" that "in order to obtain the best results the serum must be heroically administered." The writer states that heart complications of a serious nature have not been so frequent among the thousands of patients treated in a Boston hospital, nor has paralysis been so prominent. Finally, "Since the larger doses of antitoxin have been given, the death rate has been materially reduced; the reduction having occurred among the apparently moribund cases."

*The British Medical Journal* some time since (Nov. 10, 1900) advised the injection of two thousand units in *mild cases*, and four thousand to ten thousand units in cases not mild—that is "if either of the tonsils is entirely covered with thick membrane, or the palate, the nasal passages, or larynx is attacked, or if there be enlargement of the glands, fetor, increased frequency of pulse, albuminuria, pyrexia, and restlessness." In "bad" cases, sixteen thousand to twenty thousand units in twenty-four hours will be required.

*Immunization.* J. Dutton Steele, M. D., of the University of Pennsylvania (*Therapeutic Gazette*, July 15, 1901) cites 17,516 immunized cases collected by Biggs, of which only 129 developed mild diphtheria in thirty days: twenty patients were attacked after thirty days; and in all *there were but two deaths*.

There seems to be a variety of opinion as to the duration of the artificial immunity thus induced, but at all events the tendency is unquestionably in the direction of larger doses. As the author just quoted says: "The dose (immunizing) which was originally placed at two hundred to five hundred units has advanced so that now from five hundred to one thousand units are more frequently given." It is a well-known fact that the Klebs-Loeffler bacillus may be and has been repeatedly found in the throats of immunized nurses and others exposed to diphtheria, without the appearance of clinical symptoms of the disease.

*Stamping out Epidemics:* In order to check the spread of diphtheria in any densely populated community, two measures are essential, viz.; isolation and immunization by the injection of one thousand units of antidiphtheritic serum. Inasmuch as the micro-organisms have been found in the throats of convalescents for two weeks after recovery, there is always a possibility that their virulence may survive the period of immunity conferred by a small prophylactic dose of serum. Hence, the great importance of using a sufficient amount of this harmless agent whenever necessary to employ it as a preventative measure. There is every reason to believe that the initial immunizing dose for a child under

ten years should be at least one thousand units, and when the patient's environment subjects him to repeated exposure the injections should be given at intervals of not less than three weeks.

*Municipalities and Manufacturers:* There is another aspect of this subject that is worthy of the thoughtful consideration of the medical practitioner. Recent agitation by the newspapers has prompted the health officers of some cities to venture to undertake the manufacture of antitoxin. That this is a dangerous procedure has been demonstrated, notably in the case of the city of St. Louis. A safe antitoxin cannot be made successfully except under the most favorable conditions. The essential details of a delicate scientific process cannot be entrusted to stable boys or unskilled laborers. Only perfectly sound animals can be utilized. They must be housed in large, airy, well-lighted and drained buildings, equipped with aseptic fittings. They must be cared for with the most scrupulous fidelity to the principles of hygiene, and must be under the constant care of trained veterinarians. The appointments of the laboratories must be perfect. The appliances must be absolutely sterile during the entire process. This involves a vast outlay of capital, and the employment of high-salaried and thoroughly trained men. The equipment of Messrs. Parker, Davis & Co., including their great twin stables, represents an outlay of nearly half a million dollars. Municipalities can find ample room for all their energies, facilities, officials, and employees in proper municipal prophylaxis.

*Federal Supervision:* The United States Government recognizes the importance of a perfect equipment for this work, and now, after a thorough inspection by the Bureau of Public Health and Marine Hospital Service, issues a license to those manufacturers who can comply with its rigid requirements. *It is needless to say that municipal laboratories, not being engaged in interstate commerce, do not come under the jurisdiction of United States laws,* and therefore do not have the benefit of rigid government inspection—an inspection so severe that, rather than undergo the expense necessary to comply with the requirements of the United States Government, a number of small concerns have withdrawn from the industry.

In regard to the subject of the present method of classifying serum under one grade, the remarks of Dr. B. R. Shurly, of Detroit, which appeared in a recent issue of *Pediatrics*, are of special interest. The writer says: "A fatal error has frequently come under my observation, that of mistaking the meaning of the classification, Double X Serum. Double X serum refers to twice the bulk or concentration of the product, but no increase in antitoxic value. In other words, two thousand units Single X are identical in curative value with two thousand units Double X. The majority of physicians who have used antitoxin occasionally fall into the serious and fatal error of believing one to be twice the value of the other. It would seem necessary to request the laboratories

manufacturing antitoxin to make the directions and title of the product so clear that no possible confusion can arise. Under the present system the mistake is leading to fatal results."

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#### TETANUS AND ANTITETANIC SERUM.

The season of the festive toy-pistol being now at hand, the following compilation is considered apropos. An infection followed by such a dread mortality is deserving of our most careful study, and the views submitted are from authorities of established and well-earned reputations.

It has been shown that guinea-pigs and other animals inoculated with the poison of tetanus, survive when treated at once with antitetanic serum. In France, Nocard observed 375 animals of various kinds, all of which had been wounded, accidentally or surgically, and subjected to tetanic infection. These animals were given antitetanic serum at once, before the disease had time to develop. As a result, not a single case of tetanus occurred among them. On the other hand, he noted 55 traumatized animals that had been exposed to tetanic infection, every one of which developed the disease.

In the August, 1899, number of *Medicine*, Prof. Geo. F. Butler, M. D., says: "Dr. Joseph Hughes, one of the most eminent and conservative veterinary surgeons in Chicago, has used the serum as a prophylactic in over 500 cases following wounds, both surgical and accidental." Not a single case of tetanus has developed, though Dr. Hughes has used the serum where by former experience he was justified in expecting the disease to manifest itself.

From this and similar reports it has been proposed to immediately inject antitetanic serum in every case of traumatism of a suspicious character, hoping in this manner to prevent the subsequent development of tetanus. The serum is harmless to man, and may be given hypodermatically, as the other serums. Nocard recommends that a first injection of ten cubic centimeters should be made as soon as possible after traumatism. A second injection should follow in from twelve to fifteen days.

It has been suggested to inject prophylactically all new-born infants in certain sections of Europe in which trismus neonatorum prevails.

In the *Therapeutic Gazette* for February 15, 1903, the editor directs attention to the fact that "although tetanus is, comparatively speaking, a rare disease, it is sufficiently frequent and fatal to make an antitetanic serum a much sought for remedy." He also pointed out the fact that the failure of antitetanic serum depended "not upon the fact that it was possessed of no virtue, but rather because it was used too late to combat the disease." The same writer expresses the view that "one fact stands out above all others, and that is, that thoroughly good results can not be expected from antitetanic serum unless it be given in the very earliest stages of the infection. So true is this that experienced observers have insisted that its best results can be obtained only when it is administered

immediately after exposure to infection, without waiting until the micro-organisms have had a chance to develop in the body and produce early symptoms of poisoning.

The editor of the *New York Medical Journal*, in the issue of March 26, 1904, remarks that "the present drift of opinion seems to be to the effect that tetanus antitoxin, while probably of considerable prophylactic efficacy, is of little use as a curative agent.

At a meeting of the Paris Society of Surgery, according to the same editorial, M. Labbe expressed the view that since the injection of antitetanic serum has been employed as a routine prophylactic measure, the disappearance of tetanus after surgical operations in horses was a prime fact in support of its preventive efficiency. Furthermore, recent experience in the immediate topical employment of antitoxin in cases of toy-pistol injuries, appears to support our trust in its prophylactic value.

Bazy (Bulletins et Memoires de la Societe de Chirurgie de Paris, 1896, N. S., XXII, 186, 191), had four cases of tetanus develop in his wards. From that period he applied preventive treatment to all cases of wounds admitted to his service. He made 21 preventive inoculations of 10 cubic centimeters each. None of these patients developed tetanus, although he says their wounds belonged to that category which includes most cases of the disease.

Dr. Joseph McFarland, in the *Journal of the American Medical Association* for July 4, 1903, reports the results of a series of observations upon 800 horses which illustrate the value of antitetanic serum as a prophylactic agent. During a period of four years there had been a death-rate of 10 per cent from tetanus, in spite of all precautions. A systematic immunization with antitetanic serum was then begun. Injections of 10 to 25 cc. of serum were given every three months. As a result the death-rate from tetanus rapidly decreased, and in the second year had been reduced to less than 1 per cent. The author believes that the practical conclusions to be drawn from these observations may be applied to the human subject. He thinks that antitetanic serum should be given as a prophylactic measure in all cases of suspicious wounds that are likely to be followed by tetanus.

Experiments made on guinea-pigs by this author demonstrated that the dried serum fully protects inoculated animals.

At the twenty-ninth annual meeting of the Mississippi Valley Medical Association, held at Memphis, Tenn., October 7, 8, and 9, Dr. S. C. Stanton, of Chicago, contributed a valuable statistical paper on "The Prophylaxis of Tetanus" (*The Medical News*, October 31, 1903, page 860). Among the various prophylactic measures recommended by the author were the open treatment of all wounds, however insignificant, in which from the nature or surroundings there was any risk of tetanus; the immediate use of antitetanic serum in all cases of Fourth of July wounds, wounds received in barnyards, gardens, or other places where the tetanus bacillus was likely to be present, or tetanus infection to occur.



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## Obituary.

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### NATHAN SMITH DAVIS, M. D.

Dr. N. S. Davis, one of the founders of the American Medical Association, first editor of *The Journal*, pioneer of scientific medicine, a pillar of strength to the American medical fraternity, died at his home in Chicago, on the morning of June 16, aged 87.

From the editorial notice in the *Association Journal* of June 25th, we extract the following, which we most sincerely endorse.

"In the death of Dr. Nathan Smith Davis the medical profession has lost a member who always stood for the highest and noblest in ethics, in morals, and in right living. Dr. Davis worked long and earnestly for high ideals in medicine, and for the betterment of his profession in every way. He presented before the people the best and purest in that profession, and he always advocated that which he believed to be for the welfare of his confreres and for the good of the people. . . .

"He was a typical representative of the old school family physician : he had the confidence of his patients, was loved, honored, and respected by them, and withal was a welcome friend and counselor in every family in which he was known. His was a character to be emulated.

"Would that there were more men in our profession like him!"

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WHAT TWO PHYSICIANS USE IN CHOLERA INFANTUM.—"I have many such cases in which peptenzyme has worked the same way in stopping vomiting and purging. I have so much confidence in the preparation that, when I see a child in this stage, I tell the parents that after one or two doses of this preparation the vomiting will cease. So far I have yet to hear of my first failure with peptenzyme."

\_\_\_\_\_, M. D., New York.

"I have been especially pleased with peptenzyme in cases of cholera infantum. I have had no trouble in controlling vomiting and diarrhoea, and bring my little patients out of danger in about one-half the time usually taken to cure such cases."

\_\_\_\_\_, M. D., Illinois.

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HOW TO AVOID PRESCRIBING OPIUM AND MORPHINE.—Dr. N. B. Shade, of Washington, D. C., in an article published in the *Medical Summary*, refers to many unfortunate effects of prescribing opium and morphine, intimating that the depressing after-effects of the administration of these drugs more than offsets the temporary good accom-



plished by their use. He mentions a very prominent congressman whose life, in his opinion, was cut short by the administration of morphine, hypodermically, in the case of pneumonia. Dr. Shade states that he still prescribes morphine, but very seldom, as he finds it much safer to use papine. Papine, in his opinion, possesses all the desirable qualities of opium with the bad qualities eliminated. Some of the brightest minds of the present age are now being devoted to the development of a therapy in which the primitive bad effects of many important drugs are eliminated. Where the therapeutic action of morphine or opium is desired, would seem to be a safe procedure to give papine a trial.

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**GOOD HYPNOTIC COMBINATION:**—Dr. A. H. Ohmann-Dumeaenil, under of June 1, 1904, writes as follows:—

There are numerous occasions when resort to a hypnotic becomes a matter of imperative necessity, and in the choice of such remedy several factors of interest present themselves for consideration by the conscientious prescriber. Such a preparation must be *safe, certain, and prompt*. In any cases it is demanded that it must also *relieve pain*. In prescribing that a haphazard selection of a hypnotic with which to meet a multitude of conditions causing insomnia is no more admissible than prescribing for any other serious pathologic state, I have made a careful study of the various preparations of this kind in the market. In consideration of the formula presented by the Tilden Company under the name Narkogen, convinced me that it should perfectly meet the demands upon a perfect hypnotic described above, and a trial of the remedy further convinced me that Narkogen is a step in the direction of definite therapeutics for conditions which need definite diagnosis and treatment as much as any others.

Narkogen, consisting as it does of—

Chloral Hydrate, grs. 10,  
Potass Bromide, grs. 10,  
Hyoscine Hydrobromate, grs. 1-200,  
Narkine (Tilden's), grs. ss.,

each fluid dram, will, of course, have a wider range of usefulness than a mere hypnotic. It is decidedly anodyne, relieving pain promptly. It exerts a prompt, anti-spasmodic action, and is unsurpassed as a nerve sedative. It is antiphlogistic, exercising a powerful influence upon both the vaso-motor and general circulation. Its various component parts are synergistic, and each enhances the action of the other, all tending in the direction of quiet nerves, quiet circulation, oblivion to pain and mental stress, and the allaying of nervous erethism.

For the benefit of readers who do not know what Narkine is, it is a very superior opium preparation from which deleterious qualities have

been eliminated. It gives a dominant tone to this rational and effective preparation which will amply satisfy any physician who will give it a trial.

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**NERVOUS FEVERS**—To give vitality to the patient and strengthen his resisting power, Daniel's Conct. Tinct. Passiflora Incarnata should be prescribed in cases of typhoid and malarial fevers. The first object of the physician is to reduce the tension of the nerves, and enable the sufferer to enjoy refreshing sleep. This is the province of Passiflora. It is prepared from the May-pop, vine and fruit, and is the most reliable sedative and hypnotic known to the medical profession. In the treatment of morphinism, Passiflora is being employed to exceptional advantage. By its use a rapid reduction of the opiate can be made and several excellent recoveries have recently been reported. It quiets, braces, and equalizes the nervous system.

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**SOMETHING TO CONSIDER**—After many trials of a remedy that has previously given you satisfaction, have you ever experienced a time when results seemed to fail? You evidently presumed your old stand-by had lost its efficacy, when in reality, upon investigation, you will many times find that your patient is taking a worthless substitute, and not the genuine product. Dysmenorrhœa, that most painful affliction of women, readily responds to treatment with Hayden's Viburnum Compound, and as this well-known remedy is always uniform in composition, uniform results follow its administration.

All reputable products are imitated, which is the best evidence of the value of the original preparation, therefore, where pain is manifest, it is important that the genuine Hayden's Viburnum Compound be administered.

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**A HYPNOTIC WITHOUT DEPRESSING EFFECT**—Sound sleep is imperative to the recovery of a patient. It matters not how well advised the other treatment of the case may be, if the nerves are not quieted, and the body refreshed by slumber, the nervous system will give way, and sooner or later complete collapse will follow. For such cases nothing can excel in its happy but harmless effects the concentrated tincture of passiflora incarnata Daniel's.\* It is both hypnotic and sedative, and is indispensable to the physician in treating all cases attended by insomnia, hysteria, nervous headache, and nervous irritability, because it possesses the power of inducing healthful sleep, and restoring the nerves to their normal vigor. The remedial action of passiflora, which most appeals to the observing practitioner is, that it not only allays irritation, but leaves the patient in the most desirable condition—composed in brain and body.

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\* Jno. B. Daniel, Atlanta, Ga.

**PUTREFACTIVE PROCESSES**—As an antiferment, to correct disorders of digestion, and to counteract the intestinal putrefactive processes in the summer diarrhoeas of children, Listerine possesses great advantage over other antiseptics in that it may be administered freely, being non-toxic, non-irritant, and non-escharotic: furthermore, its genial compatibility with syrups, elixirs, and other standard remedies of the *Materia Medica*, renders it an acceptable and efficient agent in the treatment of diseases produced by the fermentation of food, the decomposition of organic matter, the endo-development of fetid gases, and the presence or attack of low forms of microzoic life.

An interesting pamphlet relating to the treatment of diseases of this character may be had upon application to the manufacturers of Listerine, Lambert Pharmacal Co., St. Louis, Mo.

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**GOOD AND SEASONABLE**—A word about some remedial preparations which the busy practitioner will find always useful, particularly at this season of the year, will no doubt be of interest. First, we will mention the old time-tried antikamnia and salol tablet, so useful during the hot weather, when even the "grown folks" load up their stomachs with the first offerings of the season. Hare says: "Salol renders the intestinal canal antiseptic and is the most valued drug in intestinal affections." The anodyne properties of antikamnia in connection with salol render this tablet very useful in dysentery, indigestion, cholera morbus, diarrhoea, colic, and all conditions due to intestinal fermentation. Then the "triple alliance" remedy, so well and favorably known by its self-explanatory title, namely: "Laxative Antikamnia and Quinine Tablets." To reduce fever, quiet pain, and at the same time administer a gentle tonic-laxative, is to accomplish a great deal with a single tablet. Among the many diseases and affections which call for such a combination, we might mention coryza, coughs, and summer colds, chills and fever, biliousness, dengue and malaria with their general discomfort and great debility.

We cannot overlook our old friend the antikamnia and codeine tablet. The efficacy of this tablet in neuroses of the larynx is well known, but do all of our doctor friends know that it is especially useful in dysmenorrhoea, utero-ovarian pain, and pain in general caused by suppressed or irregular menses? This tablet controls the pain of these disorders in the shortest time and by the most natural and economic method. The synergetic action of these drugs is ideal, for not only are their sedative and analgesic properties unsurpassed, but they are followed by no unpleasant after-effects.

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**WHERE HYSTERIA** is the result of uterine troubles, Aletris Cordial Rio, combined with Celerina, is an excellent remedy.

**FIRST INCEPTION OF COCA WINE** — Coincident with the earliest scientific presentation in Europe, about 1859, of the physiological properties of coca by Dr. Mantegazza, and of the investigation of its chemical constituents by Professors Wochler and Niemann, and before the alkaloid cocaine had been described, Mr. Angelo Mariani, a pharmaceutical chemist, of Paris, France, prepared a wine from coca leaves which represented their full restorative qualities as employed in the Andes. This tonic-wine has ever since borne his name, and is known throughout the world by the proprietary title Vin Mariani. During nearly half a century this preparation of coca has been maintained of uniform excellence, with a distinctive quality that its numerous imitators have failed to approach. The reason of this must be obvious to the thoughtful. With the advance in improvements in various pharmaceutical processes, Mr. Mariani has adapted to his extensive manufacturing plant every means that might tend to keep the details of his product near to the high standard of his first ideal. This was the more earnestly desired because of the accumulated encouragement of thousands of practitioners who have endorsed Vin Mariani as a tonic of sterling worth.—*The Coca Leaf*, November, 1902.

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DR. WALTER LINDLEY, the editor of the *Southern California Practitioner*, has recently been elected Dean of the Medical College of the University of Southern California. This Los Angeles school is now entering its twentieth session. Dr. Lindley was one of the organizers of the school and is Professor of Gynecology in that institution.

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**ENTEROCOLITIS AND CHOLERA INFANTUM** — Cleanse the intestinal tract with calomel and a saline, or with castor oil. Prescribe a suitable diet, easily digested and non-irritating. Irrigate the rectum and colon at suitable intervals with normal salt solution or some mild antiseptic, using for the purpose a soft rubber catheter or colon tube.

Instead of the opiates, which lock up the secretions and thereby favor auto-intoxication, relieve the muscular rigidity, and the excruciating pain which is such a drain upon the vital forces, by the use of antiphlogistine as hot as can be borne to the entire abdominal walls and covered with absorbent cotton and a compress. If the patient is not too far gone, the effect will be astonishing. The little sufferer, who until now has been tossing in agony and restlessness, with drawn features, will in most cases quickly become quiet; the drawn look will leave the face and a restful slumber will often supervene and start him upon the road to recovery.

The explanation of this, in part, is not far to seek. The heat and moisture combined with antiphlogistine's well-known hygroscopic properties, directly soothe the inflamed parts, reflexly contracting the visceral bloodvessels and relieving their engorgement. The tension of the mus-

cular and nervous systems is further relieved by the action of antiphlogistine through the solar plexus, thus adding to and emphasizing its local effects upon the inflamed intestines.

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## *Reviews and Book Notices.*

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IMMUNE SERA, HAEMOLYSINS, CYTOTOXINS, AND PRECIPITINS, by A. Wasserman, M. D., of the University of Berlin; Translated by Charles Bolduan, M. D. 12mo. cloth, pp. 85. Price, \$1.00. John Wiley & Sons, 43-45 E. 19th, St., New York, Publishers, 1904.

Those interested in Serum Diagnosis and Therapy will find in this translation of Prof. Wasserman's lectures some very interesting and valuable suggestions. He claims that it is but an introduction to the essentials of the subject. The book will be sent to any address postpaid, on receipt of the price.

THE MOTHER'S MANUAL, A Month by Month Guide for Young Mothers, by Emelyn L. Coolidge, M. D., Visiting Physician to the Out-Patient's Babies Hospital, New York; formerly House Physician to the Babies' Hospital, New York, etc., 12 mo., cloth, illustrated, pp. 263. Price \$1.00, net. A. S. Barnes & Co., Publishers, New York, 1904.

This book presents with clearness and brevity precisely the information which every young mother asks.

It is a practical manual, indispensable in emergency, immediately helpful, and in touch with the most recent developments of modern science. It is absolutely trustworthy. Facts, rather than theories, are so lucidly arranged that they make it a handbook of permanent value.

A MANUAL OF CLINICAL DIAGNOSIS, by means of Microscopical and Chemical methods, for Students, Hospital Physicians, and Practitioners, by Charles E. Simon, M. D., of Baltimore. Fifth edition, thoroughly revised and enlarged. Illustrated with 150 engravings and 22 plates in colors. 8vo., cloth, pp. 695. Lea Bros. & Co., Publishers, Philadelphia, and New York, 1904.

The demand for a new edition has been considered by the author not only as an expression of professional approval, but also

as giving an opportunity of keeping his work up with the advances in this most important department of medical knowledge. His effort has been to give the best methods plainly and practically, in accordance with all needed instructions, and to render the work as modern and practical as possible. Besides a thorough and careful revision, this edition embodies much new matter that has been brought out in the literature of the past two years.

The blood, technique, methods of staining, leucocytosis, kryoscopy, with sections on paratyphoid fever, gonococcus septicemia, bubonic plague, trypanosomiasis, spotted fever, and other special features have claimed proper attention. Illustrations have been added whenever necessary to fully elucidate the text.

The book is dedicated to his wife, to whom the author expresses his acknowledgement for material aid, especially in the preparation of some very excellent plates.

A MANUAL OF FEVER NURSING, by Reynold Webb Wilcox, M. A., M. D., LL. D., Professor of Medicine in the New York Post-Graduate Medical School and Hospital; Consulting Physician to the Nassau Hospital; Fellow of the American Academy of Medicine, etc., etc. 8vo. cloth, pp. 236, price \$1.00. P. Blakiston's Son & Co., Publishers, 1012 Walnut St., Philadelphia, Pa. 1904.

This little volume consists of the lectures on fever nursing which were delivered to the nurses of St. Mark's Hospital during the winter of 1903-4. The subject has been comprehensively and practically treated, and in accordance with the latest accepted views. Far more is to be accomplished by proper nursing than therapeutics in the management of most fevers, and we can very consistently commend this little book.

CLINICAL TREATISE ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Prof. Dr. Carl von Noorden, Senior Physician of the City Hospital in Frankfurt, a.M. Authorized American edition, translated under the direction of Boardman Reed, M. D. Part I., "Obesity: The Indications for Reduction Cures." 50 cents. New York: E. B. Treat & Company.

The first part of this book is devoted to simple obesity in persons otherwise healthy, considered in regard to its various degrees or stages. In the second part he takes up the compli-

cations of obesity with other diseases, notably with diseases of the Circulatory System, Diseases of the Kidneys, Chronic Pulmonary Disease, Chronic Articular Rheumatism and Gout, Diseases of the Nervous System, Diabetes, and Pulmonary Tuberculosis. Nowhere else can the physician find so much thoroughly up-to-date information upon this important subject contained in so small a space.

**A TEXT-BOOK OF MECHANOTHERAPY** (massage and medical gymnastics). For Medical Students, Trained Nurses, and Medical Gymnasts. By Axel V. Grafstrom, B. Sc., M. D., Attending Physician to the Gustavus Adolphus Orphanage, Jamestown, N. Y. Second edition, revised, enlarged, and entirely reset. 12mo of 200 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Company, 1904. Cloth, \$1.25 net.

The second edition of this useful little work has been entirely rewritten, reset, and very much enlarged. Two chapters have been added—one on massage of the eye, ear nose, and throat, and the other on pelvic massage. Seventeen new illustrations have also been added. The author states that his object has been to present a work that would be useful as a text-book to students, trained nurses, and medical gymnasts, and as a reference book for the general practitioner, and in our opinion he has fully accomplished his purpose. It is certainly a practical and clear consideration of the subjects of massage and medical gymnastics, and it is with pleasure that we recommend it to our readers. The mechanical get-up is all that could be desired.

**DISEASES OF THE NOSE AND THROAT**, by D. Braden Kyle, M. D., Professor of Laryngology and Rhinology, Jefferson Medical College, Philadelphia; Consulting Laryngologist and Rhinologist, and Otologist, St. Agnes' Hospital. Third edition, thoroughly revised and enlarged. Octavo volume of 669 pages, with 175 illustrations, and 6 chromo-lithographic plates. Cloth, \$4.00 net; Sheep or Half Morocco, \$5.00 net. W. B. Saunders & Company, 1904, Philadelphia, New York, and London.

In presenting to the profession the third edition of this work the general plan of the previous editions has not been materially altered. The entire book has been carefully revised and such additions have been made as were rendered necessary by recent medical progress. The most important alterations and additions



have been made in the chapters on keratosis, epidemic influenza, Gersuny's paraffine method for the correction of nasal deformities, and in the one on the X-rays in the treatment of carcinoma. The etiology and treatment of hay fever have been partially rewritten and much enlarged, as has also the operative treatment of deformities of the nasal septum. In the chapter devoted to general considerations of mucous membranes and hay fever the author records the results of his experience in the chemistry of the saliva and nasal secretions in relation to diagnosis and treatment. The literature has been carefully reviewed, and a number of new illustrations added, thus bringing the work absolutely down to date.

OBSTETRIC AND GYNECOLOGIC NURSING, by Edward P. Davis, A. M., M. D., Professor of Obstetrics in the Jefferson Medical College, and in the Philadelphia Polyclinic. 12mo volume of 402 pages, fully illustrated. Second edition, thoroughly revised. Polished Buckram, \$1.75 net. W. B. Saunders & Company, 1904, Philadelphia, New York, and London.

The usefulness of this book to the nursing profession is manifest by the fact that a second edition has been called for. It is necessary for an obstetric nurse to possess some knowledge of natural pregnancy and its consequent diseases; and as gynecologic nursing is really a branch of surgical nursing, special training and instruction are required to meet the conditions arising. This book just fills the need, everything that the obstetric and gynecologic nurse should know being included. The second edition shows evidence of having been carefully revised throughout, and considerable new matter has been added. It would be well if every trained nurse possessed a copy of this book, for it certainly is of inestimable value.

EPILEPSY AND ITS TREATMENT, by William P. Spratling, M. D., Superintendent of the Craig Colony for Epileptics at Sonyea, N. Y. Handsome octavo volume of 522 pages, illustrated. Cloth, \$4.00 net. W. B. Saunders & Company, 1904, Philadelphia, New York, and London.

This work by Dr. Spratling is of unusual interest for many reasons: It is the first complete treatise on epilepsy since the appearance of Echeverria's work published over thirty-three years



ago, and represents the practical experience of Dr. Spratling as Superintendent of the Craig Colony for Epileptics at Sonoma N. Y., during a period of ten years. The great progress made in the knowledge of epilepsy and its treatment during the past fifteen years certainly demanded an accurate and careful work which would include these latest advancements. Dr. Spratling has given us all that could be desired. Of particular interest are the chapters on the psychologic and medicolegal aspects. An entire section is devoted to the all-important seizure type — Status Epilepticus; and treatment, general educational, medical, and surgical, is discussed with wisdom, thought, and conservatism. The subject is bountifully illuminated by the citation of illustrative cases; and, indeed, for the entire book we have nothing but praise. General practitioners, as well as those especially interested in epilepsy, will find the book of great value.

**RAILWAY AND OTHER ACCIDENTS WITH RELATION TO INJURY AND DISEASE OF THE NERVOUS SYSTEM** A book for Court use, by Allan McLane Hamilton, M. D., F. R. S. E., late Clinical Professor of Mental Disease in Cornell Medical College; one of the Consulting Physicians to the Manhattan State Hospital; President of the Psychiatric Society of New York; Member of the American Neurological Association. Member of the Medical Society of London, etc., etc. 8vo. cloth, pp 351, with 15 plates, 2 super-imposed charts, and 36 illustrations. Wm Wood & Co., Publishers, New York, 1904.

This book is intended for Doctors of Medicine as well as lawyers, and especially for use in court. The author's experience in accident cases during the past thirty years, enables him to present correct views, without being biased by extreme views leaning either to the side of the plaintiff or the defendant, and endeavoring to be always just, while not fearing to attack fraud on the one hand, on the other recognizes the effects of the hysterical and exaggerated cases in which a neurotic predisposition may exist. He endeavors to give due consideration to just claims of the suffering, yet does not lose sight of the fact that the railroad company should not be overlooked. It is the author's aim to present his views as simply as possible, avoiding involved statements and discussion. A glossary is provided for those not familiar with technical terms that belong to medi-

## THE SOUTHERN PRACTITIONER.

the work is not so much intended for the specialist those who go into court needing practical help. The value as the unquestioned advantage of wide experience, affords an authoritative handling of the subjects under consideration. The illustrations and the mechanical execution of the work are excellent.

**EDITION OF NOTHNAGEL'S PRACTICE: DISEASES OF THE INTESTINE AND PERITONEUM**, by Dr. Hermann Nothnagel, of Vienna. The volume edited, with additions, by Humphrey D. Rolleston, M. D., F. R. C. P., Physician to St. George's Hospital, London, England. Volume of 1032 pages, fully illustrated. Cloth, \$5.00 net; Half bound, \$6.00 net. W. B. Saunders & Company, 1904, Philadelphia, New York, and London.

This new volume in Saunders' American edition of Nothnagel's Practice is the eighth to be issued, and appearing within a short time after the publication of the volume on tuberculosis, it is evidence that the publishers intend completing the series early in the next year. This, one of the most valuable volumes in the series, is by the famous clinician Dr. Hermann Nothnagel and is as exhaustive as it is practical. The distinguished Dr. Humphrey D. Rolleston, of London, England, has written most profusely, almost every page giving generous evidence of his careful editing. The editorial additions include chapters on intestinal sand, sprue, ulcerative colitis, and idiopathic atony of the colon. Appendicitis and peritonitis have been given unusual space, treatment and diagnosis receiving particular consideration. The section on intussusception has been greatly enlarged by the valuable additions of D'Arcy Power, M. D., who has made this subject his own. There are many inserts of great merit.

**INTERNATIONAL MEDICAL ANNUAL: A year-book of Treatment and Therapeutics**. 1904. Twenty-second year of publication. Price, \$2.00. L. B. Treat & Co., 241-243 W. 23rd St., New York, Publishers.

This old and familiar friend comes to us this year with all its excellencies, with the material improvement due to a further consideration of its well-earned reputation, and as its

duty, well and faithfully performed, has been to place before the profession everything pertaining to advancement and progress, its publishers and contributors could not permit the semblance even of a step backward or even a lagging in former success. By this time it is so well, widely, and favorably known that commendation at our hands is not needed. In collating the twenty-second edition preference has been given to those facts bearing directly on the practical side of professional work. It is a condensed, practical, and instructive compilation of the past years' progress. Some very handsome plates are a very marked feature of the volume.

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### *Selections.*

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**MITRAL' DISEASE FOLLOWING INFLUENZA.**—At a meeting of the Medical Society of the Hospitals, MM. Cornil and E. Barie reported the case of a woman, previously of excellent health, and without morbid antecedent, who was attacked by a moderately severe influenza and soon after by a secondary infection involving the heart, kidney, liver, and spleen.

The infectious manifestations principally involved the heart. For twelve days the patient had been extremely debilitated and the subject of intense dyspnœa. The latter was due to congestion of both lungs consecutive to ulcero-vegetative endocarditis of the mitral valve.

In addition to the presence of vegetative and fungous nodosities there was also a partial rupture of the larger segment of the mitral. This floated into the cavity of the ventricle. There was also a valvular aneurism, perforated at its center, and situated upon the smaller segment of the valve. The latter is an exceptional occurrence, for valvular aneurisms, as Drasche has shown, generally occupy the larger segment. This valvular rupture and aneurismal dilatation were the consequences of particularly rapid, ulcerative action in the course of post-influenzal infectious endocarditis.

Infection was due to the staphylococcus. The kidneys were also particularly involved. Without being exceptional, acute post-influenzal nephritis is quite rare, occurring, according to Freman, in one per cent. of the cases.—*La Tribune Medicale*.

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A UNIQUE ACCIDENT.—H. C., about forty years of age, weighing about two hundred pounds, came home late at night in a "festive condition." Inserting his key in the door lock, his foot slipped and he fell with his face, respectively his mouth, on the edge of the key, severing the tissues below the gum and the sublingual gland.

When I arrived at the house he was vomiting profusely. However, when the vomiting ceased for a while, I noticed blood oozing from behind the lower lip, intermixed with a yellowish, somewhat frothy liquid, pouring out in gushes. I endeavored to stop the flow, but did not succeed owing to the repeated vomiting spells.

At last I succeeded to inject hypodermically a half a grain of morphine, in consequence of which a cessation of vomiting followed shortly.

After a careful examination of the injured parts, I concluded it could be but the sublingual gland which emits the secretions, and was not a little surprised at the enormous quantity, as to my knowledge this gland is very small and weighs only one dram. I intended to put some stitches in the tear, but patient protested against it in his semi-intoxicated condition. I had to resort therefore to the application of strips of adhesive plaster to the surface of the lower lip, thus compressing the severed parts.

As a matter of fact, this procedure stopped the evacuation and I left patient in quite a comfortable condition.

The beneficial action of the morphine, however, was of short duration, as I was summoned again about two hours after, with the frightened remark that patient is suffocating.

When I arrived, I found patient hanging down his head from the bed, gasping for breath, as some food-masses could not pass through the mouth owing to the compressed chin. I tore off the bandage, and with the contents of the stomach, the little

gland commenced to flow with renewed vigor. By this time, the man having sobered somewhat, after some arguments he permitted me to put in the necessary sutures.

Notwithstanding the internal administration of some stomachics, the irritation continued, vomiting would not cease. I was compelled to inject hypodermically another dose of morphine, which after some minutes stopped that wretched retching.

The next day, however, as the effect of the morphine passed away, vomiting recurred.

Considering the fact that a simple alcoholic irritation of the stomach would yield to the prescribed treatment, I concluded that it could be but the swallowed secretions of the sublingual gland which caused this persistent irritation.

First, I considered a washing of the stomach, but, as previously, I met with the opposition of patient.

As a matter of course, there was only an internal medication left for consideration. I decided, therefore, on a simple innocuous antiseptic — glycozone — with which I had quite a satisfactory experience in several cases of ptomaine poisoning. I prescribed it in repeated tablespoonful doses with rapid and gratifying results.

Notwithstanding the liberal use of antiseptic washes and sprays, the wound in the mouth was healing but very slowly.—*Alex. Rixa, M. D., of New York, in Medical Summary, January, 1904.*

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THE TONSILS AND DISEASE.—W. S. Anderson (*Detroit Med. Jour.*) states that in chronically enlarged tonsils we have a number of affections traceable to them. The crypts of the tonsils afford an excellent lodging place for particles of food, which, together with the secretions into the crypts, supply the proper medium in which innumerable pathogenic organisms thrive. The decomposing material gives a foul odor to the breath, interferes with normal digestion, and may cause gastric disturbance. Absorption of septic material from the crypts causes infection of the lymphatic glands of the neck, with enlargement and possibly suppuration. When enlargement of the glands of the neck exist one should seek for the point of infection. This may be found to be due to disease of the ear, nose, naso-pharynx, tonsil, teeth,

or larynx. The most frequent cause is disease of the tonsils. The tonsils may not be very much diseased, and yet, if examined carefully with a bent probe, diseased crypts will often be found, forming blind pouches, through which infection may take place.

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RELATION OF PHYSICIANS TO DENTISTS.—Dr. John S. Marshall, U. S. Army, in a paper read by Dr. Alexander R. Craig at the recent meeting of the American Academy of Medicine, considered the subject from the professional and ethical standpoints. He quoted definitions of physician, medicine, surgery, dentist, and dentistry. Exception was taken to the definition of dentistry and the following offered: "That department of medicine and surgery which relates to the study of the diseases, injuries, and irregularities of the teeth, their treatment and preservation, the replacing of lost teeth by artificial substitutes, and the treatment of the diseases, injuries, and deformities of the oral cavity, the jaws, and the accessory sinuses." The education of the dentist is comparable to that of the physician, and the dental surgeon may be classed as a specialist in medicine. From the ethical standpoint the same claim holds for the true dentist.

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GONORRHEAL CONJUNCTIVITIS.—Oliver (*Therapeutic Review*, January 1904) states that in early cases of gonorrheal conjunctivitis fatal or indifferent ocular results will be avoided by the following treatment:

1. Free, gentle, and repeated cleansing of the surface of the infected tissues with sterile water applied through a bulb syringe by an experienced nurse.
2. Early obtainment and maintenance of full pupillary dilatation, with the removal of all undue iridic and ciliary muscle action by means of atropine, or, when necessary, scopolamine, supplemented by atropine.
3. Lowering the invading micro-organisms' vitality by the constant use of iced compresses, which however must not be applied to eyes which such treatment would injure.
4. Maintenance of the organs' vitality, especially where there are trophic disturbances, as in corneal involvement, by the topical application of heat.

5. Destruction of the intruding floral germ-cell material with the least possible disturbance to faunal cells of involved part by gently patting the exposed areas of the palpebral mucous structures with weak solution of nitrate of silver.

6. Isolation of patient and protection of unaffected eye.

7. Support and improvement of patient's general condition by copious ingestion of easily digested and assimilable foodstuffs, by the graded but copious internal use of sterile water, strict emunctorial hygiene, and organic corrective when needed.

8. Skilled nursing, as long as examination shows presence of gonococci germ.

These rules must be closely adhered to until some days after examination has shown that the gonococcal infection has been completely eradicated.

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THE DIAGNOSTIC VALUE OF LEUKOCYTOSIS.—Fernand Bezancon and Marcel Labbe (*Gaz. des Hopitaux*, June 6, 1903) state that polymuclear hyperleukocytosis is the rule in acute suppuration; this fact is of value in the diagnosis of appendicitis and of pelvic suppurations. In a patient suffering from fever with a typhoid state, the demonstration of leukocytosis with polynucleosis would point to some frankly inflammatory process, and exclude typhoid or miliary tuberculosis. Malaria gives a mononuclear hypoleukocytosis. In cachetic conditions, not accompanied by fever, the presence of polymuclear hyperleukocytosis with anemia may lead to a diagnosis of cancer. In the differential diagnosis of ganglionic tuberculosis, lympho sarcoma, and simple lymphadenitis, an examination of the blood is of the greatest value; the last-named affection alone showing a normal number of leukocytes with predominance of mononuclears.—*Medical Record*.

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CHANGES IN THE PULSE DUE TO STIMULATION OF SPECIAL SENSES.—The effect on the pulse of stimulating the senses of hearing, taste, and smell has been carefully studied by M. Heitler. The sphygmograph showed a distinct acceleration in the pulse rate of ward patients when a noisy street car passed the windows, and the same effect was also observed when other sounds were

produced. It was found that a clanging sound was followed by a greater acceleration than that produced by other disturbances, and, moreover, that high notes had more effect than deep tones. Tests made on the sense of smell showed that vinegar and camphorated oil produced an increase, whereas turpentine, alcohol, and benzine were followed by a depression in the pulse rate. Concentrated solutions of various substances placed on the tongue disclosed that sugar and salt produced an acceleration, vinegar and quinine a depression in the pulse. These observations were made in over two hundred patients.—*Centralblatt für innere Medizin*.

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A NEW STAIN FOR THE MALARIAL PARASITE.—Josef Koreck (*Deut. med. Woch.*, April 23, 1903) gives the following stain for the malarial parasite: Argentum methylene blue, 1 g.; aceton, 2 g.; distilled water, 10cc.; eosin, 8 to 1.5 g. The argentum methylene blue is made by adding .5 g. of collargol to 100 cc. of a 1 per cent. aqueous solution of methylene blue. The smear is fixed by any of the usual methods and submitted to the action of the stain for a varying length of time depending upon the age of the staining solution. If the latter has been freshly prepared nearly one-half an hour is necessary, but if it has been allowed to age a much shorter time will suffice. In any given instance the proper time can only be ascertained by repeated trials. The advantage of the method is the sharp differentiation given by it between the red blood cells and the parasites, so that when the latter are ill defined with other methods they are plainly brought out by this one.—*Medical Record*.

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THE ETIOLOGY OF AFFECTIONS OF THE LEFT HEART IN CHILDHOOD.—L. Concetti (*La Riforma Medica*, March 11, 1903) concludes from his researches that acute polyarticular rheumatism is the most frequent cause of acquired cardiopathies. In children endocarditis from rheumatism or other infections is more rare than in adults. The majority of cardiopathies in children which are supposed to be acquired, are really the result of arrested or faulty embryonal development, exhibited before birth or in the first years of extrauterine life.—*American Journal of Obstetrics*.



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The absolute safety of Listerine, its well defined antiseptic power, and the readiness with which it lends itself to combination with other indicated remedies, are properties which have led many physicians to adopt Listerine as the antiseptic foundation of their prescriptions for Summer Complaint.

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## Prescriptions and Formulary.

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### ANÆMIA.

Sacchari lactis, ..... 3 iss.  
℞ Cupri arsenitis, ..... gr. j.  
Alcohol, ..... q. s.  
M. et ft. tabellæ No. 48. Sig. One after meals.

Indications. — Of value in anæmia which does not yield to other hæmatics. — *Ex.*

---

### ACNE ROSACEA.

J. E. Lockridge (*Med. World*) cured a case of acne rosacea of twelve years' standing, the prominent red nose, not alcoholic in this case, with the following prescription:—

℞ Lac sulphur, ..... 3 j.  
Camphor,  
Tragacanth, ..... aa gr. x.  
Rose water, ..... 3 iv.

M. Sig. Apply night and morning. Leave on over night, and apply early in the morning and wash off before going out. — *The Med. Standard.*



# One Hundred for \$1.00 Have you tried NAPHEY'S WAFERS?

They are unsurpassed as a positive and speedy cure for Diseases of Women. They have been successfully prescribed by Physicians for ten years. We have increased the size of boxes from 25 to 100, which we are selling at the same price, \$1.00 per box, which puts them in the reach of every Physician for office use. Send for samples and literature.

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## TREATMENT OF CONSTIPATION IN INFANTS.

The *Medical Summary* says:—

“A very successful remedy for constipation in infants is podophyllin, in small doses; iridin may be combined with it with good effect. Make a tincture of the following:—

“ Podophyllin resin..... gr. viij.  
Iridin..... gr. v.  
Aromatic spirit of ammonia..... ℥j.

“Sig.: Digest for several days and filter.

“One or two drops of this may be given at bedtime on a small piece of loaf sugar, or the dose may be combined in mixture along with syrup of orange. This is the dose for a child of one year and under.”

## SYPHILITIC ULCERS.

Some authors recommend the following combination in the treatment of syphilitic ulcers:

R Hydrarg. chloridi mitis, ..... ℥ j.  
Ichthoformi, ..... ℥ ss.  
Petrolati, ..... ℥ viss.

M. Sig. Apply locally; or:

Iodol, ..... ℥ j.

Sig. Apply freely to the ulcer.—*Jour. Amer. Med. Association.*

**CHATTANOOGA MEDICAL COLLEGE**



F

℞ Sodi sa  
 Tinct. f  
 Acid cit  
 Glycerin  
 Ol. gaul  
 Liq. am  
 M. Sig. T  
 four hours. — *Soli.*

To stimulate the  
*cal Record*:—

Strychn  
 Pilocarp  
 Sacchar  
 M. Ft. cap.  
 Sig.: (

#### CALCIU

G. Goss, in *Kli*  
 chlorid administered  
 nephritis, also in  
 profuse hemorrhag  
 may be given as

Calcii c  
 Aq. de  
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The same may be  
 Calcii cl  
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THE MEDICAL ECHO, Lynn, Mass.

### ASTHMA.

Dr. W. has a patient, a man, 35 years of age, who has suffered for two years with asthma. Lately a paroxysm occurs almost every night. His appetite is poor and after eating he is always conscious of a "heavy load" upon his stomach. The bowels are generally constipated. He has lost flesh and strength. A paroxysm leaves him feeling very tremulous and exhausted. Sometimes he will break out in a cold, clammy sweat. An attack lasts from half an hour to two hours and a half. It is said that in the absence of wheezing no rales are heard and that there is no vesicular emphysema.

This is a good, concise account of a typical case of asthma. The disease has been probably excited by the condition of the alimentary canal. Upon this supposition I should order:—

Potassii iodidi,..... ℥ iss.

Syrup. ipecacuanhæ,..... ℥ x.

Tinct. lobeliæ,..... ℥ vj.

Syrup. sarsaparillæ co., q. s. ad..... ℥ viij.

M. Sig.: Teaspoonful three times a day.

For the attacks I should order:—

Antimonii et potassii tartratis,..... gr. xij.

Pulveris ipecacuanhæ,..... ℥ ss.

M. et ft. in chart. no. xij.

Sig.: One powder to be taken at the first sign of an attack.

Patients usually have premonitions of an attack, and even the wife can sometimes foretell their occurrence by the wheezing before there is much difficulty in breathing. In such a case the paroxysms are aborted or shortened by emesis.

I should also let the patient have some capsules containing  $\frac{1}{4}$  minim each of amyl nitrite, to be taken when a paroxysm is impending if the vomiting did not produce marked relief.—*Med. Bulletin.*

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### *Original Communications.*

#### THERAPY OF SODIUM CHLORIDE.\*

BY J. S. NOWLIN, M. D., OF SHELBYVILLE.

It was my original intention to write a more extended history of the many uses to which this salt has been applied as a therapeutic agent. Recent sickness, together with the loss of memoranda by fire in my office, precludes the fulfilment of this desirable purpose at this time.

Chloride of sodium is one of the most important constituents of the blood, and is in double the proportion of any other inorganic salt. It maintains the alkalinity of the circulating fluid and the tissues as well. The power of endosmosis and exosmosis is enhanced by its presence, which we will notice later as an important factor. When taken into the stomach it aids digestion by the formation of sodium lactate, setting free the hydrochloric acid and favoring the formation of pepsin.

\*Read at meeting of Tennessee State Medical Association, April 13, 1904.

Senn says, that "normal salt solution is antiseptic, and is extensively used in cleansing recent wounds; that it is far better than sterile water, because it does not irritate the tissue or interfere with rapid repair."

He also claims, as I think very correctly, that death from hemorrhage results in consequence of loss of power of intravascular and intracardiac pressure, incompatible with the proper function of the circulating organs.

He further claims that the circulation can be maintained in its intravascular tension to the required degree by substituting for the blood lost, an equivalent quantity of normal salt solution.

I have no doubt the clinical experience of the members of this Society will sustain this opinion. I am sure it accords with my own observation. I want to say, however, that I do not believe it is necessary to use an equivalent quantity of the solution. The salt, when in a normal proportion to the aqueous fluid, has within it a *dynamic* force which at once awakens the latent or paralyzed forces of the intima in the whole vascular system, from the heart to the capillaries.

The strength and temperature are matters of importance. It is safely placed at a 6-10 of 1 per cent. solution of chemically pure sodium chloride.

This is approximately made with one teaspoonful of the salt to a pint of water at a temperature of 120°. The temperature can be safely approximated by immersing the whole hand in water as warm as it will comfortably bear. I have never used it intravenously, not having found it necessary, neither is it so safe as when introduced hypodermically or per rectum. The rapid transit of this fluid through the whole system is an all-important desideratum. It is fortunate that this potent therapeutic agent has the endosmotic and exosmotic power within itself.

There will possibly be some surprise and disbelief when I say that the rectum is the quickest route by which to reach the ebbing life when blood has been or is being rapidly lost. There are two reasons for this: First, the rectal mucosa is the most favorable surface for absorption found in the alimentary canal;

second, it is the only place where the agent introduced passes into the system without a greater or less degree of change.

A saline solution holds the blood corpuscles in form without breaking down. It invites the fluid directly from the tissues in resupplying the quantity. This fluid thus drawn from the tissues of the body has a ready vitality within it, not inherent in any fluid made by hand of man or in a chemical laboratory. It is better, therefore, that it should be placed where it will at once stimulate the endosmosis and exosmosis which is so rapidly and constantly at work in the process of metabolism. Herein is its dynamic power, and this must not be neutralized by an excessive quantity.

I mention one other reason for using this medicine per rectum. It is this: any irritation about the rectum or pressure upon the sphincter muscle, or distension of the walls of the rectum from the anus to the sigmoid flexure, is a stimulant to the respiratory and cardiac nerves, as also to the whole trophic nervous system.

This can be demonstrated by dilating the anus of the still-born babe. It is also efficient in excessive narcosis from chloroform. Thus far we have noticed the effect of salt in such conditions as when life is in imminent danger from loss of blood. I am convinced that in the near future it will find a broader field of usefulness.

There is no question in my mind but that it is a strong antiseptic. It was long since used and believed to be beneficial in tuberculosis. It was used quite extensively and for a time with favor. It was given by mouth, and also applied by bath; bathing in sea water was evidently attended with benefit, and was of more benefit when taken by the bath than when taken by the stomach. This was doubtless true.

I am sure from some experience in that direction, that salt taken into the stomach does not reach the diseased tissues as a diuretic and diaphoretic.

I herewith present some conclusions drawn from the effects of this solution given per rectum in a case which I saw with my friend, Dr. G. W. Moody. The patient was a primipara. From the seventh month she evinced an albuminuria to which he gave constant and intelligent attention. He regulated her diet and

administered medical treatment recognized as the best in such cases. She was of short stature, quite round, and of considerable flesh. He controlled for the most part the swelling of the extremities. There was no disturbance of vision until the final ending of pregnancy by delivery almost at term.

For nearly two weeks during the last month, there was no movement of the fetus, neither heart sound that he could find. At this time there was quite a reduction in quantity of albumin, though it never entirely ceased. On Friday she complained of dim vision. Saturday morning he delivered her of a still-born child, which had evidently been dead for several days. This was at 4 A. M. She was quite cheerful and bright and apparently doing well when he left her at 8 o'clock; about noon she told her nurse that she was blind. He saw her very soon and bled her freely; he saw no evidences of actual convulsions, though the blindness continued and she became delirious and almost unconscious. He invited me to see her with him during the night. He had given her saline solution, morphine, veratrum, and active purgation.

Kidneys acted very scantily; skin dry; she was very restless, and constantly talking incoherently.

The treatment was continued, and I suggested the salt solution be continued by giving half a pint of the solution at intervals of three or four hours per rectum. Dr. Moody agreed to this.

I had noticed in uterine hemorrhage when used to support the circulation, that the skin and kidneys become more active. This I believed to be a desideratum in eclampsia, and that the failure in the directions of elimination, especially that of the kidney, was because the medicines introduced by stomach never sufficiently reached the lower abdominal viscera from the mechanical pressure of the uterus and resultant congestion.

I think the portal circulation is obstructed in this way and that medicines by the rectum are absorbed and carried directly to the kidneys, the function being stimulated thereby.

This agent has been used by transfusion in uremia and found beneficial. There is good authority for saying that albuminuria in pregnancy is not the sole cause of eclampsia. It is taught that the phenomena called eclampsia may be caused by vitiated

secretions in utero, for example, from urine of the fetus, or toxic condition of liquor amnii, diseased placenta, etc.

I am of the opinion that salt solution is antiseptic in these conditions and eliminative as well. That the eclampsia cannot be the result in all cases of uremic poison is proven by the fact that so many pregnant women pass albuminous urine and go to term in safety.

This solution was continued for 48 hours, perspiration became free and active, quantity of urine was increased, she was quite thirsty under its effects, and the circulation strong and full. The capillaries of the hand were so full that they seemed swollen. The enema was partially suspended at this time, though not entirely discontinued. Under this line of treatment the mind was gradually restored, and also vision, but not quite so rapidly.

I close this hastily written paper, which can only be suggestive, with the proposition that normal salt solution, in addition to other therapeutic power, will be recognized as the natural physiological stimulant of the so-called failure of the heart. Strychnia is relied on and indiscriminately used for imaginary weak heart, oftentimes to the extent of paralyzing the cardiac action. The heart is muscular, and strychnia when given in full influence has its powers directly upon its contractility. It is often given when no fault is in this direction. The fault is in the stimulating forces of the blood, and this is inherent in its alkaline and absorptive forces which can be strengthened by salt without detriment elsewhere. Let us not forget that while the nervous system is an adjuvant, the life is in the blood. We must not impose on the heart when the fault is a want of attention to the general vascular system. Intravascular pressure is wanted in many cases where the forces have been exhausted by disease, not the loss of blood. A safe and efficient remedy will be found in normal saline solution.

#### DISCUSSION.

DR. W. J. BREEDING, of Taylors: *Mr. President:* I desire to endorse that phase of the paper referring to the use of normal salt solution and blood-letting in the treatment of puerperal eclampsia by reciting a couple of cases that occurred in my practice within the last year.

The first case was a primipara, twenty-eight years of age. I was called in consultation with three other physicians. She had been having con-

vulsions at regular intervals of from twenty minutes to half an hour, and the treatment employed by the physicians in charge was chloroform inhalations, hypodermics of morphia, at intervals, and veratrum viride. There was no dilatation of the os uteri, no labor pains, but patient began to have convulsions and became unconscious. We continued this line of treatment, and decided to rupture the membranes and wait for labor pains for a short time. We only waited about two hours, when the patient went into convulsions and died. We all discussed the case very thoroughly after the patient's death, deciding that we would try blood-letting and hypodermoclysis in our next case of convulsions. Soon afterwards I was called in consultation to see another primipara, having convulsions at regular intervals, and we decided to resort to blood-letting and normal saline solution. So we at once abstracted a quantity of blood, and injected per rectum a large quantity of saline solution. The patient never had another convulsion, and went on and had a normal delivery. I believe that is the treatment for puerperal convulsions. I do not believe in veratrum viride. I do not believe in injecting poisonous veratrum into a patient who is suffering already from blood poisoning ; I believe the rational treatment is to relieve blood tension by blood-letting, chloroform inhalations to control convulsions, and dilute the toxic agent, whatever it may be, that is circulating in the blood, by injecting normal saline solution.

DR. S. S. CROCKETT, of Nashville: I think it very healthy for us to have happen occasionally just what has happened this evening, namely, to have our attention directed to a common remedy that is too uncommonly used. Dr. Nowlin is appreciative of the fact that any constituent of the body that predominates so much as chloride of sodium does in the human body, must of itself be possessed of considerable therapeutic value under certain conditions. We all know that chloride of sodium is a salt that contributes largely to the alkalinity of the different structures of the body, and especially to the plasma of the blood. We know that the sodium salts do another thing, and especially does it apply to the chloride of sodium—they increase the alkalinity of the secretions and contribute to the increase in the quantity of the alkaline secretions of the body. This is particularly true of chloride of sodium. It is estimated that there is about one-quarter pound of chloride of sodium in the human body. The chloride of sodium especially, among the soda salts above all other agents we possess, increases the function of excretion through the liver. We know that the liver, perhaps up to a few years past, has not secured that recognition it deserves as the emunctory of the body. We have a long time thought that the kidney and skin did most of the elimination from our bodies, but we now know, and indeed the French authorities maintain, that the eclampsia the essayist spoke of is very often of hepatic origin. They speak of it as a hepatic toxæmia that originates in the liver, and the doctor is striking at the source of the infection when he

administers those agents that increase the fluidity of the biliary secretion and increase its quantity. I have no doubt the method he refers to is one of the best that can be adopted to combat toxæmia. Furthermore, I have no doubt this would offer the best results in all cases of toxæmia, blood-letting being followed by hypodermoclysis. Unfortunately, Mr. President, we are too busy with great things to recognize small things when we see them, or we overlook them too often in managing these cases ; we too often wait until eclampsia is on the woman. If we could recognize the danger signals in advance, and see them in front of us as distinctly as the red light upon the railroad, either in the eye or head, the ear, or headache, tinnitus aurium, pain in the stomach, or vomiting, we could undoubtedly accomplish much for these patients. It is a great mistake to suppose that a woman is not going to have eclampsia because there is no albumen in the urine. This is the greatest misfortune that can be gotten into the mind of any man. About fifty per cent. of all pregnant women, at times, have albumen in the urine, but no other symptoms present. About five or six per cent. have albumen in good perceptible quantities. Of this five or six per cent. that have a good quantity of albumen in the urine, they rarely escape eclampsia. If we would recognize albumen in the urine as a symptom of toxæmia; that the convulsion is not going to be caused by albumen in the urine or a renal lesion, but they are both caused by the same thing, it is better to treat the patient, and not wait for albumen to appear in the urine, or for any other renal lesion to manifest itself, but we should recognize the premonitory symptoms with reference to the stomach especially, and treat the condition before the convulsion appears. I know of nothing better than the treatment suggested by the essayist, namely, free purgation, blood-letting, followed by normal salt solution. How? Any way you can possibly get it into her body. Let her drink it. If she cannot drink it, is unconscious, give it by the skin, give it by the bowel, give it to her now and repeatedly. How much? As much as you can possibly get her to take. If we would do this, we would ward off the convulsions. The fact is that when a man has a case of convulsions in a woman during this period, he considers it a reflection upon his management of the case. At any rate, he should feel that way. He should try to ward off the convulsions, and I believe it can be done.

We cannot ward off the convulsions unless we watch systematically for the premonitory symptoms, and not wait until albumen appears in the urine.

DR. G. W. MOODY, of Shelbyville: I think Dr. Crockett is right when he says that a physician ought to feel that it is a reflection on him when he has a patient in whom convulsions occur in connection with labor. I have thought this for years. The symptoms are very noticeable in these cases, and manifest themselves in advance of any convulsion. If we give our patients the proper attention and care during pregnancy, we will rarely, if ever, have a case of eclampsia in parturition.



The patient referred to by Dr. Nowlin was under my care during the period of pregnancy; she was a primipara, and knowing her well, and that she had a low stature and lymphatic constitution, I thought from the beginning of pregnancy she was liable to have uremia, or that disordered state of the blood in which convulsions occur, whether attributable to the liver or to the kidneys. So I began to examine the urine, but did not find any indication of albumen until about the beginning of the sixth month, although I had examined her urine previously. She had at that time a slight catarrhal attack, which must have been the beginning of the albuminuria. I have always been able, without exception, to relieve every woman I have found in this condition during pregnancy, so that she could pass safely through parturition. But this case progressed steadily. I gave the usual eliminative treatment; I put her on the usual diet, and finally tried a milk diet, but she could not tolerate any form of milk diet, because of gastric disturbance. It disagreed with her, and it became a question as to whether or not she got nutrition enough unless she ate other things besides taking milk. She got better at times, then worse, and labor came on prematurely. I was delayed in reaching her, as I lived six miles in the country, and telephone communication was cut off. When I reached her I found that the cervix was fully dilated. I mention this as an important thing in the consideration of the prevention of eclampsia, and you will bear in mind that this woman never had convulsions, but was in a uremic condition. Knowing that she was liable to have eclampsia, I gave her a hypodermic injection of morphia, and as soon as I could prepare my instruments and get them ready, I delivered with forceps. I was not long in delivering her. I left her in as good condition as I have ever left any woman. The pulse was normal, and there was no indication of trouble. I left her at eight o'clock; at twelve o'clock in the day I was summoned, and told that her vision was affected. She had gastric disturbance and subcutaneous oedema, but there were no symptoms of uremia, so far as I could determine. The treatment given seemed to have benefited her. Where we have not had a chance to treat a patient and ward off uremia, the injection of morphine hypodermically is an important remedy, not only in these cases, but in others. When I have been called to see a patient during pregnancy and find her in that condition, with subcutaneous oedema, etc., if, after inquiring into the history of the case, I find there is any expectation or likelihood of convulsions, I would keep her under the influence of morphine, terminate labor as soon as possible, and I have had women pass through all right, although I feared eclampsia very much. I have had a great deal of experience in these cases. I pay a great deal of attention to them, but I must confess I have never seen a case of convulsions in which there was not marked renal insufficiency.

DR. NOWLIN (closing the discussion): I want to say with regard to the management of this case from the beginning, that Dr. Moody is one of the most industrious physicians in this class of cases I have ever



met. I feel assured that if he had not appreciated the fact that this patient was in danger from the beginning, she would have lost her life. He gave her close and careful attention, particularly as to the secretion of her kidneys, and for the last two or three months he was exceedingly anxious about her. By his management and treatment of the case he undoubtedly warded off convulsions which would have occurred. She had some swelling, which he was able to control. I said to the family that I believed if the woman had not had the close attention and intelligent action of her physician, her life would have been lost.

I am very much gratified at the endorsement of my remarks by some of the gentlemen who have taken part in the discussion. I want to call attention to the fact that I believe the introduction of a saline solution into the circulation is a support to the action of the heart. I believe a very large proportion of these cases, in which there is impaired intravascular tension, or a lack of it, need something more than strychnia. If we stimulate the heart with strychnia, we are simply goading a heart which is, so to speak, very much exhausted from want of vascular pressure. The muscular tissue of the heart is in a good condition under these circumstances; it is doing its work, but the stimulating power of the blood which goes not only through the vascular system, but the cardiac centers as well, must be kept up, with proper tension, and I called attention to the fact that salt solution has the power of exosmosis and endosmosis, and that it converts fluid from the tissues of the body into the circulation. This fluid has an inherent power. It supports the system.

With regard to the use of water in these cases, abdominal surgeons will say to you, after they have performed a laparotomy, that the patient is thirsty; and I believe it is their rule not to permit such patients to drink much water for some little time. I do not know but that their theory is a correct one after such an operation. If they have used a solution of salt intra-abdominally for its antiseptic effects, the patient not drinking water, the absorption of that fluid from the tissues gets into the blood, restores its alkalinity, sustains the red corpuscles, and increases the vascular pressure, thereby supporting the heart, which would not be done if patient was permitted to use water freely during the first twenty-four or forty-eight hours after a laparotomy.

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### AFTER TREATMENT OF ABDOMINAL SECTION.\*

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BY L. E. BURCH, M. D., NASHVILLE.

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This very important subject is dismissed with a few lines in most works on abdominal surgery, and while I make no claim in this paper of bringing out anything new or original, still I be-

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\*Read at meeting of Tennessee State Medical Association, April 13, 1904.

lieve the subject is of sufficient importance to the profession to be most carefully considered. We have all had the experience of patients telling us the first few days after abdominal section that had they realized the suffering entailed, they would not have consented to operation. These pains, though quickly forgotten after convalescence, are severe enough at the time to occasion our every effort towards alleviating them. When possible, the treatment of our patients should begin about ten days before operation by getting the secretions, excretions, and blood as nearly normal as possible, and also what is very important, get them accustomed to the recumbent posture and the use of the bed-pan and urinal in this position. Immediately after operation the patient is placed on the back, the knees flexed and supported by a pillow, with a blanket next to the body; outside of this blanket hot water bottles are placed, watching carefully that no burn occurs. The bottles are removed when temperature reaches normal, and a sheet is then placed between the patient and blanket. The head should be kept low, and no pillow used until vomiting ceases. In certain cases the dorsal position is not advisable, and we then use either the Clark or Fowler position, depending on the case, as each of these is indicated in exactly opposite conditions. The Fowler position consists of elevating the head of the bed about fourteen inches, and the patient is kept from slipping by placing a pillow beneath the flexed knees and buttocks. The object of this posture is to carry the septic fluid to that part of the peritoneal cavity where absorption is least rapid, namely, the pelvic peritoneum, and from thence it is removed by means of drains. The Clark posture, on the other hand, elevates the foot of the bed; and before closing the abdomen, he pours into the peritoneal cavity a litre of salt solution. The purpose of this position is to carry septic particles to that part of the cavity where absorption is most rapid, namely, the diaphragmatic, and from thence it is absorbed and thrown off by the system. In other words, Fowler uses drainage and attempts to prevent absorption, Clark favors dissemination and absorption, allowing nature to drain and throw off the septic material. It is much better to explain to the family that they will not be admitted to the sick room for the first few days, and if we

are firm and at the same time kind in our explanations in regard to this, we will save both the patient and relatives much unnecessary anxiety.

The three most prominent symptoms after section are back-ache, thirst, and nausea. The pain in the back usually passes off in from thirty-six to forty-eight hours, but while present is the source of the greatest annoyance. If we have left the patient in bed several days before operation and let him get accustomed to the position, it is, as a rule, not a prominent symptom, but in so many cases this is not possible. Many surgeons tell their patients that it is a pain they must make up their minds to stand, and that they can do nothing for it. This no doubt is a great mistake, for it is a condition that can nearly always be relieved by mental therapeutics. We should assure the patient that we will relieve him, and by having the nurse rub the back with alcohol or place a small pillow beneath it, elevate or depress the knees and smooth out the bed clothes, we will often be gratified to see him pass into a peaceful sleep. Hypodermics of water have a marked effect on this pain, and in cases where it is quite severe, the patient can be turned on side, even during the first twenty-four hours. As a rule, however, it is best to keep them on the back until the bowels move, for the reason that the more a nervous patient's position is changed, the more it will be asked for.

Thirst can be relieved, to a great extent, in every case by giving a high enema of salt solution while under the anæsthetic, and when consciousness is regained, the face should be bathed with cool water and a gargle of tepid water used to clean out the fauces. The practice of withholding water seems to me barbarous and without reason. After consciousness is regained, the patient should be allowed cool water in moderation until the thirst is relieved, and if the enema has been used at the completion of the operation, it will take but little to satisfy them. After a prolonged operation, it is best to repeat the enema every four hours, and at the same time administer water by the mouth. At the end of twenty-four hours, if vomiting is still present, then let them have water in satisfying amounts, even if it is immediately vomited, for the reason that it gives the stomach something to con-

tract against, and at the same time acts as an irrigation to that organ. To my mind the withholding of water is only justifiable in those cases where there is quite a dissemination of sepsis over the peritoneal cavity, and we are very anxious for the peritoneum to absorb it as quickly as possible. Nausea and vomiting are the most difficult of all symptoms to relieve when present. Inhalations of pure vinegar, started as soon as the anæsthetic is removed and continued for several hours, will have a beneficial effect in many cases. In others it will be a complete failure. There are many drugs advocated for the relief of this condition. The most reliable with me has been the tincture of iodine in one drop doses repeated hourly. When the vomit becomes bilious in character, gastric lavage should be resorted to. The points over which the profession are mostly at variance are as to the use of morphia and the time at which a purgative should be administered. In certain cases the judicious administration of morphia is not only indicated, but it will have a very beneficial effect. In other cases, however, it should never be used. In those desperate cases where we are anxious to get a bowel action as soon as possible the morphia is contraindicated. On the other hand, if the operation is one in which there has been no dissemination of sepsis over the peritoneum, the patient is quite restless, tossing from side to side, is in great agony, and we have faithfully carried out other measures to give relief, morphia should be used, giving a hypodermic in doses from  $\frac{1}{8}$  to  $\frac{1}{4}$  of a grain, and repeated as often as is necessary.

There is no necessity of opening the bowels, with the average cases, until the third day. This is generally accomplished by the use of calomel, followed by a saline and encouraged by a high enema when the patient has the desire. At a critical point, when there has been dissemination and we are doubtful as to the outcome, the bowels should be moved as quickly as possible. In this class of cases if we get the bowels open, the bad symptoms disappear rapidly and convalescence begins immediately. If we are unable to move the bowels, then things go from bad to worse, until death relieves the anxiety of the physician, patient, and relatives. The early movement of the bowel is accomplished by one of several methods, each of which is about equal in its re-

sults. Some surgeons begin the use of purgatives a few hours before operation, using either a saline, calomel, or some preparation of cascara. Others put into the small intestine, when the abdomen is opened, a saturated solution of Epsom salts, closing this puncture by a Lembert suture. This method is especially suitable to those cases of appendicitis complicated with peritonitis. The various other methods are the use of castor oil placed in the stomach by means of a tube at the completion of operation, or again we may begin the use of purgatives and enemas as soon as the patient is conscious. In some few cases the administration of castor oil is advisable. When purgatives fail to act, the enema that has been most successful with me is one containing alum, a teaspoonful to a quart of water. I have seen this open the bowels when everything else failed. In the use of purgatives in desperate cases it is advisable to place the patient on the right side, so that the stomach may quickly empty the purgative in small intestine. Of course if there has been a traumatism of the intestinal tract, and we are doubtful as to the sutures placed, we should under no circumstances attempt an early movement from the bowels.

Unless the patient is in a run-down condition, no food should be given until the end of forty-eight or sixty hours, beginning first with the animal extracts, juices, broths, or egg albumin, commencing with a teaspoonful every hour and gradually increasing. Milk, the usual food that is given at this time, in my mind, should not be used until the end of the fifth or sixth day, for the reason that it is likely to curdle or increase the tympany already present. Flatulency or tympany are usually relieved when the bowels are moved, but if it persists, a rectal tube should be left in the bowel, and the stomach washed out. If this is not successful, a few light touches over the abdomen with the cautery will have almost a magical effect.

The patient should be bathed once in the twenty-four hours, going over small portions of the body at a time. For the first forty-eight hours use alcohol and water, and afterwards soap and water. The nightgown, split up the back, should be changed once in the twenty-four hours, and at the same time the upper sheet and draw sheet should be removed and fresh ones substituted. If

the abdomen has been closed in a satisfactory manner, and we have no fear as to hernia, patients should be propped up at the end of seven days, and allowed to get about at the end of two weeks ; and if the case is an old person with feeble circulation, he should be changed from side to side during the first forty-eight hours and propped up in bed at the end of three days, and in a chair at the end of a week. Of course in those cases where the pathology has existed for years with marked neurasthenic symptoms, the longer we keep them in bed the more likely we are to get a symptomatic cure. As to the treatment of shock after section, there are three measures that stand in a class by themselves. These are heat, normal saline solution, and adrenalin.

In conclusion I desire to emphasize the following:—

The avoidance of opium and the early movement of the bowels in desperate cases ; the absence of all relatives and friends from the sick room until the crisis has passed ; the administration of water in almost satisfying quantities from the first ; the early propping up in bed, especially in old people ; the avoidance of milk as diet until the sixth day ; and last, but not least, the use of a saline enema at the completion of every abdominal operation for the relief of thirst.

#### DISCUSSION.

DR. R. E. FORT, of Nashville: *Mr. President:* Probably no paper could be read which would be of greater interest to this Society, especially the practitioner who has abdominal sections left with him for post operative treatment, than the one presented by Dr. Burch. We have all been edified by it.

With reference to Fowler's position, as the doctor has explained, it has very properly been abandoned for all conditions except one, it is used with the greatest benefit in those septic cases, perforating gun-shot wounds of the abdomen, for instance, when we wish gravity to assist in the localization of septic material in the pelvis, either facilitating drainage, or placing the septic material within the pelvic peritoneum whose absorptive power is very slow, and allowing a gradual excretion of sepsis. We, of course, understand that the diaphragmatic peritoneum has the greatest absorptive power. Elevation of the foot of the bed, one of the best of the old methods of combating shock, should never be practiced in septic cases for the reason stated above.

With reference to vomiting, I have not seen the benefits from acetic acid and iodine described by Dr. Burch, in fact, I have seen little or no benefit from anything except rest and lavage.

As to diet, it is my practice to give no food for the first thirty-six or forty-eight hours. The patient is recovering from profound anesthesia intoxication, combined with operative shock; the two inhibit the process of digestion and the stomach is not in a condition to assimilate food, and if it is not assimilated, it becomes an irritant, therefore I give no food.

The relief from vomiting by lavage is so uniform and prompt that its therapeutic virtues cannot be explained. If the ordinary methods do not relieve it, lavage with patient in recumbent position should be practiced at once. I have repeatedly seen patients with persistent vomiting for twenty-four hours completely relieved by resort to the stomach tube. In fact, I have not seen it fail except in cases of septic peritonitis in which the issue was of short duration.

The question for a time of bowel action is a serious one, and with grave conditions confronting it. The class of cases in which we want an early bowel action are perforative cases and those in which resection has been done, however, in these cases, we desire peristalsis reduced to a minimum. In these cases it is my practice to delay the administration of purgatives for thirty-six hours and depend upon drainage. Ideal surgery demands no drainage, but drainage in septic cases is essential.

DR. W. D. HAGGARD, of Nashville: Dr. Burch has presented a very important paper in which he has practically covered every phase of the subject. He has told us how to meet every emergency that may arise after abdominal section. Those of us who do abdominal surgery have different ways of doing things, and naturally we think our way is a little better than any other. There are many ways which lead to Rome, and one road is perhaps about as good as the other. Formerly, the anesthetic was given to patients in bed, after which they were removed to the operating room. It was found, however, that a patient was frequently on the operating table from fifteen to thirty minutes before the operation was begun, being under the influence of the anesthetic during that time. This method has been changed. The patient is now brought into the operating room, and while going under the influence of the anesthetic the nurse makes the abdominal preparation, distracts the patient's mind from the anesthetic, which is an important thing. The element of time is important in abdominal surgery, so that by the time a patient is under the influence of the anesthetic, the abdomen is prepared, and everything ready for the operation to be begun. This plan gives a great deal of satisfaction.

Another thing: I let patients drink all the water they desire the night before operation and an hour before it. Why? Because if on an empty stomach you give a patient an anesthetic, she is going to gulp a great deal, and swallow a considerable amount of the anesthetic, which



will act as a direct irritant to the mucosa ; she will vomit and vomit, with nothing in the stomach to vomit except the irritation. If there is any water in the stomach, these things will be dissolved in solution, so to speak, and the first vomiting will get rid of that that has been swallowed. Vomiting after abdominal section depends largely upon the amount of anesthetic used. Here, again, time comes in. If you give a little of the anesthetic beforehand, and a little during the operation, it will serve the purpose, and I think the best way to give an anesthetic is by the open method, as with a wisp of gauze, giving the anesthetic drop by drop on an Esmarch inhaler ; the patient does not get suffocated. He or she, as the case may be, goes to sleep in about ten minutes ordinarily. She is under it lightly all the time. By this method it is not uncommon that the patient wakes up when put to bed. It is an ideal method of anesthesia, and I feel that every surgeon will use it sooner or later. Murphy, Ochsner, and Mayo use this method extensively. What we want is to prevent vomiting, and not be bothered about giving iodine, carbolic acid, and inhalations of vinegar. We should not give any more of these drugs than is absolutely essential. I do not put hot water bags around my patients, although this is a routine practice by some surgeons. It is so much better to do the operative work quickly, and give as little of the anesthetic as possible, as by so doing the patient does not have much shock. She does not get cold ; you do not have to put hot water bags or hot water bottles around her. I was operated on by a professional friend of mine, who came into the room with my own nurse and removed the hot water bottles she had put in the bed. He referred to a suit for damages that had been brought on this account, and he spoke against the use of hot water bags being placed in the bed after abdominal section. To prevent the necessity for their use is what you want to accomplish.

When I first began to do abdominal surgery, thirteen years ago, we followed the bad practice of starving patients ; not to give them a drop of water for seventy-two hours after operation, so that the peritoneum would absorb everything. It looked barbarous not to give a patient anything to eat or to drink during this time, after she had been given an anesthetic and had lost perhaps a lot of blood. It did not look physiological to me. I did not know very much about the after-treatment of these cases at that time, and simply followed what had been taught. Patients who had shock and had stimulating enemata had less thirst. I began to give them all enemata and water when I was a house surgeon in 1895. They did not have much thirst. I gave them in six or eight hours after operation crushed ice. If any of you ever have to take an anesthetic for an abdominal section, after the operation you will thank the Lord for the man who gives you crushed ice. Crushed ice given to these patients will enable them to get along swimmingly. It is fine. Try it.

DR. C. P. McNABB, of Knoxville: All through the day I have noticed that different remedies have been suggested for these serious failures



of the vital forces. I have heard mentioned normal salt solution, adrenalin chloride, digitalis, and strychnia, all good and excellent remedies, but it is strange to me that no one has referred to what I consider by far the best of all diffusible stimulants, namely, camphor given hypodermically, as it stimulates the failing heart and improves respiration when all things else fail.

I have had quite a personal experience with it in the Knoxville General Hospital in cases of pneumonia during the months of January, February, and March of the present year. Very many of them were in the worst possible condition, and all of them had weak hearts. I do not remember the number of patients treated, but I am perfectly satisfied that I have seen it tide patients over serious conditions of heart failure when used hypodermically. We used a five per cent. solution of camphor in sterile olive oil; one grain of camphor given every half hour, until it had a decided effect. It was then continued in one grain doses every three or four hours. It is, in my opinion, one of the best stimulants in these cases.

DR. J. M. BLACK, of Knoxville: With reference to vomiting after operations, I would emphasize the importance of having the anæsthetic fresh. In some cases chloroform is taken out of a bottle that has not been opened perhaps for six months, and administered to a patient. This is wrong. The anæsthetic should be fresh. For quite a while I have been using Squibb's chloroform, put up in small packages. Of course, the long duration of anæsthesia plays a great role in the production of vomiting, and the preparation of the patient, as spoken of by Dr. Haggard, is very important. I believe if we can prevent vomiting it is much better than to treat it after it occurs.

DR. BURCH (closing the discussion): I wish to thank the gentlemen for the kind discussion given my paper.

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## QUININE IN MALARIAL HEMATURIA AND HEMOGLOBINURIA.

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BY W. R. HAYNIE, M. D., OF HAYNES, ARK.

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Does quinine ever produce hematuria? In our opinion it does not. We base our opinion upon personal observations extending over a period of eighteen years, and our opportunities have been good for studying malarial diseases; yet we do not call to memory a single case of malarial hematuria that quinine produced the complication or played any part as an etiological factor. In our hands it has prevented hematuria when rightfully administered. Six years ago we came to Haynes from the eastern part of West Tennessee, and found on our arrival that the

physicians here believed that quinine given to patients suffering from malarial cachexia, hematuria would speedily follow. Our experience in Tennessee was the opposite, for we cinchonized our patients well with quinine and prevented hematuria and hemaglobinuria. After studying malarial diseases since our residence here we find that those that take hematuria are the cases that are allowed to go on carelessly treated, and when relapses of intermittent fever frequently occur, which soon brings about pathological changes in the liver and spleen, with disintegration of the blood cells. Quinine properly administered and at the right time will completely destroy the malarial plasmodium before these changes take place. The tertian and quartan parasites are the only causes of any of the hemorrhagical forms of malarial fever. The blood should be examined for the malarial parasites in every case if possible, but no time should be lost where the physician finds sufficient symptoms of intermittent or remittent fevers regardless of the microscopic examination of the blood. Quinine should be judiciously administered in solution, combined with mild chloride of mercury followed by sulphate magnesium. The blood should be examined as soon as possible and quinine should be continued as long as a trace of the plasmodium can be found. Since we adopted this plan of treatment we have not had a single case of hematuria to occur in our practice. The plan pursued by us in cases where the stomach rejected the drug or when the stomach seemed to be incapable of absorbing the quinine, was to use hypodermics of five to ten grains of the hydrochlorate injected every second or third hour till physiological effects are secured, then sufficiently to keep up the effect. Quinine, in my opinion, is indicated in the treatment of hematuria, especially in those cases when crescents are found in the blood. The drug need not be used when the crescents have disappeared, and the blood should be frequently examined and if they should reappear begin quinine again at once.

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FOR CORNS.—Mercks (29-s) suggests a change from the standard formula to the following: resorcin, salicylic ac., lactic ac., each dr ss; flexible collodion dr v. Apply nightly four or five days, soak and remove in toto.

## ENTEROCLYSIS.

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BY SOL. NEWMAYER, M. D., PHILADELPHIA, PA.

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Among the varied causes of convulsions none play a more frequent and important part than auto-intoxication. They are more frequent in children, due generally to a possible over-feeding, improper food; or constipation. The intestinal canal contains a variety of toxins, derived from the ingesta, bile, and putrid material. There is continuous absorption from the intestines, including the taking up of toxines.

In the acute infections, where convulsions are oftentimes a forerunner, auto-intoxication from the intestinal tract undoubtedly is of no minor importance. Infections are the result of microbes, and we know these bacteria produce something injurious to the system,—they elaborate poisonous ptomaines or toxic substances. Nature tries to rid the body of this poison through its various channels of elimination, one of which is the intestinal canal.

It is here we can aid nature with our antiseptics. The value of intestinal antiseptics I believe is greatly over-rated. Many of these drugs are soluble and absorbable, and those that are not are so often given in such small doses that they have spent most of their value before they have proceeded far.

Not to employ intestinal antiseptics would be unwise, but I would urge a more liberal use of antiseptic solutions by means of the rectal tube. This enteroclysis has not only its antiseptic value, diminishing the toxicity of the intestinal tract, but oftentimes an antipyretic action. This mode of treatment has not been very popular with the physician because of the unclean work, but I am confident the results will repay one for the labor.

In all cases of convulsions, immaterial of the cause and in any other conditions pointing to auto-intoxications, I flush the lower bowel with a solution of Glyco-Thymoline one to two ounces to the quart of water.

Glyco-Thymoline is always kept in my emergency grip.

## *Abstracts.*

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### COLLARGOLUM ENEMATA.\*

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BY DR. HEINRICH LOEBL, ASSISTANT AT PROF. SCHLESINGER'S DIVISION IN THE FRANZ-JOSEPH HOSPITAL AT VIENNA.

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During the last few years there has been a constant increase in the number of favorable collargolum publications. Good results have been recorded from its use in apparently absolutely hopeless cases, and we convinced ourselves in our division of the fact that anyone who administers it to a considerable number of septic patients will have the same experience. In serious cases we did not employ Unguentum Credé, preferring the intravenous injection of 1% Collargolum solutions ( $2\frac{1}{4}$  grains to  $\frac{1}{2}$  oz. sterile water), which we used with excellent results.

But great obesity, anæmia, venous paucity, etc., may hinder the intravenous injection. Besides, a single injection is rarely enough, and only a limited number can be given if a new vein is used for each. Finally, the needle may be displaced from the lumen of the vein by a motion of the patient when the constricting bandage is loosened.

In one case where the veins could not be reached on account of their anæmic narrowness and the patient's well-developed panniculus adiposus, we therefore used Collargolum as an enema. The method has the following palpable advantages: It can be used by any attendant, is neither painful nor troublesome, is entirely safe, permits the use of larger doses, and brings the drug in contact with an excellent absorbing surface. It is no less efficacious than the intravenous injection. The intestine is not irritated, even when 1% solutions are given for fourteen days, and the collargolum enema is almost entirely absorbed, for a cleansing enema given twelve hours later brings only a slightly blackish fluid.

Having given the enema to two dying patients and demonstrated the absorption of collargolum by histological examination,

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\* Abstracted from *Die Therapie der Gegenwart*, April, 1904.

Loebl used the enema in twenty-seven cases, which are detailed with illustrative temperature charts. Six were sepses of varied origin; of these, four were cured, one was not benefited, and one died. One of the cured cases was a staphylococcaemia in which other remedies had failed; and one other case is especially noteworthy because it appeared hopeless when the collargolum was begun. The fatal case was so desperate that the surgeon refused to operate, and even it showed some improvement the next day, so that a less marantic individual (she was sixty-five years old and tubercular) might have been saved. Out of nine cases of puerperal infection, five were cured, three were not benefited, and one died. In this series one beginning parametric infiltration with irritative peritoneal symptoms underwent rapid involution, and in five other cases there was an inhibitive effect on suppuration. In one case of obstinate rheumatism and in four cases of renal and vesical infection there were no results. Six consumptives with rapidly progressing febrile phthisis, one of them moribund, and all of them entirely recalcitrant to every internal medication, received the enemata without any special effect. In sanatoria, where there is naturally a larger proportion of mild cases, there is probably a greater chance of success.

As regards the technique, the patient is given morning and evening an enema of one or two pints of lukewarm water. Half an hour after defecation,  $7\frac{1}{2}$  grains of collargolum in 1% solution are administered by funnel or syringe. This amount ( $1\frac{1}{2}$  ozs.) is almost invariably retained; the bowels usually move only after the cleansing clyster on the next morning. The enemata are given twice daily for at least eight and not more than fourteen days. No unpleasant after-effects have been observed.

Loebl concludes that the collargolum enemata give the same results in acute infections as does Unguentum Credé or collargolum intravenously. In many cases the method has a surprising effect; and it has more than once been effectual when joint affections or phlegmasia alba dolens had appeared. It is probable that the method will save cases which we would otherwise lose.

For these reasons we heartily recommend a trial of the treatment. Since November, 1903, when he demonstrated the method in the Royal and Imperial Medical Society of Vienna, he has

received many favorable reports on it, both in hospital and in private practice.

Prof. Netter, Member of the Paris Academy of Medicine, writes in the *Bulletins et Mémoires de la Société des Hopitaux* of April 28, 1904, concerning the administration of Collargolum by mouth and per rectum. He finds that the gastro-intestinal route, which Loeb1 and Jousset have used successfully, has the advantage of simplicity, and often gives excellent results. By mouth he gives pills of 1-6 to 1-3 grain collargolum with sugar of milk and glycerin; or solutions in albuminized water,  $\frac{3}{4}$  grain to a dessertspoonful, the daily dose being  $2\frac{1}{2}$  drams to 1 oz.

For rectal injections  $1\frac{1}{2}$  to  $7\frac{1}{2}$  grains Collargolum should be given twice daily; or  $1\frac{1}{2}$  grain to  $4\frac{1}{2}$  grain collargolum suppositories may be used. Several of his patients have taken Collargolum per os and per rectum for months at a time, one without interruption for a year.

In non-infectious diseases, such as nervous and gastric affections, in which silver nitrate is used, Collargolum acts well, has no caustic effect, and never causes argyria. He gave it to six epileptics and got the specific action of bromide from much smaller than the usual doses; and the distressing symptoms of bromism and the eruptions, bad breath and mental depression were avoided. He even used Collargolum alone, and patients have passed five or six months without any attack.

He also used it successfully in several cases of neurasthenia and neuralgia. A chorea that was intractable to antipyrin and arsenic was cured by it, and it was also effectual in migraine. Given by mouth in infectious intestinal diseases, dysentery, and mucomembranous enteritis of children and adults, it gave marvelously rapid results.

The internal use of Collargolum is also preferable to injection or inunction in infectious diseases with a prolonged course, such as phthisis pulmonum. In typhoid especially the drug has a direct effect upon the pathogenic organisms, diminishing fever and diarrhoea and shortening the disease. Results in influenza were equally good. In certain tuberculosis cases Collargolum alone appeared useful. Cases with cavities seemed especially benefited; in several there was rapid diminution of expectora-

tion. In infectious endocarditis subsequent to biliary inflammation the prolonged use of the drug certainly lowered temperature and increased the patient's strength.

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## *Records, Recollections and Reminiscences.*

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### ANNUAL MEETING OF THE ASSOCIATION OF MEDICAL OFFICERS OF THE ARMY AND NAVY OF THE CONFEDERACY.

The seventh annual meeting was held in the Lecture Hall of the Medical Department of the University of Tennessee, on Broad Street, in Nashville, Tenn., beginning on Tuesday, June 14, 1904.

The following members were registered on the morning of the first day:—

Drs. Jno. R. Gildersleeve, Tazewell, Va.; A. P. Fitch, Lebanon, Ind.; N. P. Reeves, Longstreet, La.; T. C. Wheeler, Lebanon, Tenn.; J. M. Dennis, Hopkinsville, Ky.; W. H. Barnes, Homewood, Miss.; J. S. Cain, Nashville, Tenn.; J. C. W. Steger, Gurley, Ala.; W. B. Maney, Nashville, Tenn.; James C. McConnell, Newbern, Tenn.; P. B. Bacot, Florence, S. C.; J. P. Moore, Yazoo City, Miss.; J. D. Croom, Maxton, N. C.; Frank Ferrell, Ashland, Miss.; G. W. Johns, Atlanta, Ga.; A. J. Beale, Cynthiana, Ky.; J. M. Keller, Hot Springs, Ark.; S. R. Sayers, Witheville, Va.; J. B. Cowan, Tullahoma, Tenn.; Alfred Jones, Cornersville, Tenn.; Joseph W. Hunter, Waco, Texas; Thomas R. Wingo, Trezevant, Tenn.; De Sausure Ford, Augusta, Ga.; Gordon B. Edwards, Richmond, Va.; James W. Henson, Richmond, Va.; Charles T. St. Clair, Tazewell, Va.; Wm. B. Cummings, Bishop P. O., Tenn.; A. A. Lyon, Nashville, Tenn.; Thos. L. Patterson, Charleston, Mo.; John L. Dismukes, Mayfield, Ky.; Wm. F. Beard, Shelbyville, Ky.; Frank M. Beard, Shelbyville, Ky.; Samuel L. Beard, Shelbyville, Ky.; N. S. Snyder, Hot Springs, Ark.; Edwin D. Newton, Milledgeville, Ga.; T. P. Lockwood, Crystal Springs, Miss.;

Wm. U. Martin, Kingston, Ky.; John J. Scott, Shreveport, La.; G. H. Tichenor, New Orleans, La.; and Carroll Kendrick, Kendrick, Miss.

The meeting was called to order at 9 A. M. by Chairman of the Executive Committee, Dr. Geo. H. Price, Nashville, Tenn., who introduced Dr. J. Bunyan Stephens, pastor of the Primitive Baptist Church, who offered the following prayer:—

“Supremely great, transcendently glorious art Thou, our heavenly Father. Thou who rulest in the armies of heaven and among the inhabitants of earth, and none can stay thy hand, or by way of opposing thy doings, have a right to say, Jehovah. Thou art our great preserver and our bountiful benefactor. Thou hast blessed a few of us with health and strength to assemble at this place this morning. Now draw near to us that we may draw near to Thee, that everything this morning may be done pleasantly, decently, and in order, that this moment may be remembered long and never forgotten. We are swiftly passing away. The scenes and circumstances that now know us will soon know us no more forever. Many of our comrades are dead and gone. A few of us are yet living, and are now going down the steeps of time. Oh God, give us days of happiness and pleasure during our last days on earth. Now what more can we say to thee, our heavenly Father! Bless us in this meeting. Bless us through our lives. Be with us in all of our trials and in all of our troubles, and in all of our tribulations, and finally at last may we “pass over the river and rest under the shade trees” on the other shore. These blessings we ask in the name of, and for the sake of, Christ our Redeemer. Amen.

Dr. Price then introduced Dr. J. H. McNeilly, pastor of Glen Leven Church, who delivered the following address of welcome on the part of the city of Nashville:—

*“Comrades of the Association of Medical Officers of the Army and Navy of the Confederate States:—*

The members of your noble profession in Nashville have conferred on me a high honor, as well as given me a peculiar privilege, in appointing me to give voice to their sentiments of respect and affection for you, as you are gathered here to recall the services and the sacrifices which you wrought and endured “in





# VANDERBILT UNIVERSITY

## MEDICAL DEPARTMENT.

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### FACULTY.

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Histology, Pathology and Bacteriology.

**J. T. ALTMAN, M.D., Professor of Obstetrics.**

**RICHARD A. BARR, B.A., M.D., Professor**  
of Abdominal Surgery and Physician to the Dispensary.

**LUCIUS E. BURCH, M.D., Professor of Gynecology.**

**SAMUEL S. BRIGGS, M.D., Professor of**  
Anatomy.

**OWEN H. WILSON, B.E., M.D., Clinical**  
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**A. B. COOKE, M.A., M.D., Clinical Professor**  
of Proctology.

**W. FRANK GLENN, M.D., Clinical Professor**  
of Genito-Urinary and Venereal Diseases.

**G. P. EDWARDS, M.D., Clinical Professor**  
of Neurology, Dermatology, and Electro-Therapy.

**J. A. GAINES, M.D., Adjunct Professor of**  
Practice of Medicine.

**W. A. BRYAN, M.D., Adjunct Professor of**  
Surgery.

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High school and first grade teachers' certificates constitute the minimum requirements for entrance. College graduates are permitted to take the first and second years' work in one session. The entire course covers four years, and is strictly graded. The work of each year must be completed before any student can be advanced to the studies of the next succeeding year. Certificates of proficiency from other reputable medical colleges will be accepted, and students from such colleges will be advanced accordingly. Our college and hospital clinical facilities have never been so good, for under a new city law the clinical staff will have control of all charity patients. We welcome post graduates and encourage post graduate work. The next session begins Monday, October 3, 1904. Prospective students should write to the Secretary

DR. G. C. SAVAGE,  
139 N. Spruce Street,  
Nashville, Tennessee.

the brave days of old ;" while you ministered to suffering humanity with a skill and fidelity which were as modest as they were heroic. Your brethren of this later day and peaceful time wish to express their appreciation of your work in the past ; their admiration for your character, which was moulded in the fiery furnace of war ; their gratitude for those exalted professional ideals, which you illustrated in your daily duties in camp, in hospital, or on " stricken fields of strife." Under most difficult conditions you preserved those ideals of honor, integrity, and kindness untarnished by any shadow of meanness, cowardice, or cruelty. With a devotion to duty that counted not the cost, that responded at once to every call of suffering, that ministered with unfailing patience to the sick, the wounded, and the dying, you set an example to the generation following you which has inspired it with the same grand purpose to sacrifice self for the help of others.

Therefore I am commissioned to address to you a few words of welcome to our hearts and homes. Probably the reason why I was chosen for this pleasing service, is that I have had exceptional opportunities for observing the faithfulness with which the members of your profession, as a body, have stood, both in times of war and of peace, to the post of duty, when it was also the post of danger. For in both times there are occasions when you are put to the proof, and when battle or epidemic tests your mettle. During the four years of civil strife my work was akin to yours. As a Chaplain of a Brigade, seeking to promote the spiritual welfare of the men, I chose my place with the Assistant Surgeons, messing with them in the camp, and on the field of battle going as near as possible to the contending lines, that we might render immediate help to the wounded. Then with the Surgeons afterward, assisting in the more serious work, carrying my roll of bandages, my bottle of morphine, and my canteen of whiskey, I soon learned to be an effective aid in ministering to the wounded, and keeping death at bay, until more skillful hands could come to the rescue.

Then for thirty-five years as preacher and pastor in this city, it has been my privilege to be with the physicians in periods of epidemics, when " the pestilence walked in darkness and destruc-

tion wasted at noonday," to meet them by the bedside of the sick and the dying, as they waged warfare with Death, to see the gentleness, the patience, the skill with which they alleviated suffering or conquered disease. And it gives me pleasure to testify that not only were you of the Army and Navy true to your high calling, but these also for whom I speak to-day, and who gladly honor you, were themselves also equally faithful in their lot and station. As I have seen this grand devotion to duty in the face of personal peril and danger, I am reminded of a significant figure discovered in excavating the ruins of an ancient city of the East. On a Greek coin or medal is stamped the figure of a bullock standing between a smoking altar and a plough. Beneath is this inscription (Greek) "Elkatero prothumos eimi," "I am ready for either," that is, ready to offer up life a sacrifice on the altar of duty, or to use life in service to men.

So, my comrades, you stood in the fierce battles of the olden days, so your younger brethren stand to-day, with your lives ready for sacrifice or service, as the Providence of God may appoint.

The circumstances of your war-time experience brought out, manifested and developed some of the finest traits of character, and some of the most effective devices of skill and science in your profession. Your fertility of resource was remarkable. I know not whether it is according to the usages of civilized warfare that medicines and the instruments of surgery are contraband of war, but surely it is not to the credit of the opposing government that it strictly prohibited the bringing into the Confederacy of these necessities of a humane civilization. But when you were shut out from the medical stores of the world, your genius and energy explored nature's great laboratory, and discovered her secrets; and from field and forest, from cave and stream, you brought forth her healing agents.

Your inventive faculties were exercised to manufacture instruments with which you performed operations in surgery, which, being repeated to-day, with all modern appliances, call forth the wonder and admiration of your profession. And yet your modesty made no boast of your work. You were so absorbed in the blessed ministry of healing and help to the suffering that

you did not take time to think of the greatness of your achievements. It is a duty which your Association owes to your successors to preserve the record of your work. There was developed a quickness of response, a readiness to act in the sudden call of need, which was of untold value in the saving of life. The emergency was so sudden, the wound often so unusual, there was no time for sentiment, nor for discussion. You needed all your faculties to come at once into action. It required a coolness and steadiness of nerve that might almost appear callousness or indifference to suffering. It is a profound remark of Dr. John Brown, in his splendid dog story, "Rab and His Friends," in which he excuses the apparent levity of the doctors at a capital operation, that with them pity as an emotion is dulled, but pity as a motive is quickened by their familiarity with scenes of suffering. So your experiences might appear to harden the sensibilities, but they made you prompt to respond to the motive of mercy. It is needless to remark at length upon the courage which you displayed amid the awful scenes of the battle. I never saw a surgeon desert his post from fear of personal danger. It is true that among the doctors there were some who were somewhat vain and boastful when the enemy were distant, just as in every other branch of the service, and there were some who were slaves to red tape, and a few who were weak in the presence of whiskey. But in the mass of them there was that profound sense of professional responsibility which made them strong, brave, courageous men, defying death in the performance of duty, and keeping them free from formalism or sensuality, that they might the better do their work of help. Let me also bear testimony to your magnanimity. There was no petty spirit of revenge against a wounded enemy. As soon as he was helpless, in your eyes he ceased to be an enemy, and became a brother who needed your help, which was freely given. All the resources of your profession were bestowed upon the wounded Federal soldiers who fell into our hands. And it was by such chivalrous bearing to a fallen foe that much of the horror of war was mitigated. But, comrades, long and earnest as has been your warfare against Death, nobly as you have saved others in days gone by, yet your bent forms and dim eyes and hoary hairs proclaim that soon you

## THE SOUTHERN PRACTITIONER.

st yield to his power. It can not be long until we, upon whom  
: has snowed so many winters, must cease from earth's labors  
l companionships. We must fight our last battle, and be num-  
ed with the dead upon the field of strife. Let us thank God  
t your lives have not been in vain, that you leave behind you  
inspiring example of duty faithfully done to encourage those  
o are here to welcome you to-day.

And as these opportunities for our meeting on earth are be-  
ning fewer, let us make the most of them. Let the hearts that  
re been bound together in the past by common sufferings and  
rifices now thrill with tender sympathy and love for each  
er. And as we look forward to that near though unseen  
rld to which we are journeying, it surely will not be out of  
ce for me to remind you that there is a Great Physician, Jes-  
rist the Lord, who has conquered Death, and brought life a-  
nortality to light. He went about healing diseases when l-  
s on earth. You have been doing the same kind of work  
days of your pilgrimage. He, in the fair world, where si-  
s and death can not come, awaits those who have taken l-  
their Leader. And I surely hope that in that glorious l-  
shall all meet in a reunion which shall continue foreve-  
npanionship which shall never be broken. And now as  
nd within the gates of our city, around whose walls the  
the guns resounded, and the red tides of battle surged  
rs ago, in whose homes peace now reigns with sweetest l-  
tions, we rejoice that you are yet spared to us, the survi-  
a heroic age. And with tender memories of the past, v-  
irtfelt love in the present, with bright hopes for the eter-  
ure, in the name of the physicians and surgeons of Nashv-  
greet you, my comrades, and bid you ten thousand times  
ousand welcomes.

Dr. Price next introduced Hon. John H. DeWitt, of Nashv-  
nn., who welcomed the Association in behalf of the Sons  
nfederate Veterans.

*dies and Gentlemen:—*

It is not particularly the organization known as the "Sons  
nfederate Veterans" which I would represent to-day.  
rather my desire to speak in the spirit of the number pres-

of the coming generation to you, the veterans of the South. I esteem it a very great privilege to stand here and talk to you, because there has never been anything more sacred in my life than the knowledge of the heroism and glory that are spread upon the pages in history in the record of Confederate Veterans. It is very hard, gentlemen, to deliver a message to the Veterans here to-day, or anywhere in this city, as a representative of my generation. God Almighty never gave to a man to speak the deepest, truest, most intense emotions of his heart. There are things which are too deep and too sacred for human words. There are emotions which can not be expressed, because they go to the very foundation, the human soul, and are emotions which find exercise within. Gentlemen, to greet you on behalf of us, or on the part of the sons of Confederate soldiers, is a peculiar pleasure, for the reason that we realize that you had a very noble part in a great epoch in the history of the world, and to us who have the shouldering of the burdens of on-coming days, and the civilization which we must maintain, and which we have a very strong duty in maintaining, because you have laid the foundation of it so liberally and grandly, I would say that we have a peculiar privilege to deliver a message to the Confederates. We are proud of Confederate soldiers. I do not think that there is any more honor to be attached to any name than that of Confederate soldier. He fought the most valiant war in history, and when that war was over, after having fought valiantly, and having no reason for regret to be marked in field, in prison, or anywhere. He had no cause to regret that he had not fulfilled the noblest ideals of a soldier, in any clime or part of the country. You, gentlemen, were privileged to minister unto him. You by your skill and your resources were able to keep that army going to fulfill the work which it was endeavoring to do.

We are proud of what the Confederate soldier did, not because he stood upon the field and faced danger when danger was great, but because the Confederate fought for great and undying liberty, and pursued truth and virtue, which had been handed to him, and thought it was necessary to go into the field in order that they might be maintained for his children and his children's

## THE SOUTHERN PRACTITIONER.

ren. As we look upon this character in history, we realize in him is the basis for the best of character building we can n. The love of virtue, public and private, the delicate sense ersonal honor, the highest sense of chivalry, the sense of to family and state, the obligations he undertook to fulfill everybody personally and to society as an organization, in the Confederate soldier has left to us an example which ould be unworthy of if we do not endeavor to follow closely; f we do not endeavor to build enduringly upon this example, an not be worthy of our father's name.

ntlemen, it is pathetic to view the Veterans who are assem- here, those who have come with limping and halting steps, : whose eyes are dim and whose hair is white, those who come to show from year to year their love for their com- s, and their ardent affection for the memories of the cause which they fought. We have no nobler example before us this. We have nothing that appeals to our hearts more, brings us more closely together than this spectacle which is efore us in this city. God grant that we of this generation be able to shoulder and maintain all the burdens that may upon us. God grant that in bearing these burdens we may worthy of the noble purpose which you espoused, and that may maintain that devotion to duty and heroism which you ldiers and physicians showed in other days when necessary. grant that it may be ours in the coming days when you are ered in those up squares, where your comrades sleep, to up and carry on the work of civilization in this generation, make it what God Almighty would have it be.

ie response to the addresses of welcome was made by Dr. W. Steger, of Gurley, Ala., and is as follows:—

*cs and Gentlemen:—*

is unexpectedly that I have been called upon, since I came is room, to acknowledge our gratitude for the kindness and esy that have been shown to this people in inviting us again me to this city in order that we may for the third time renew acquaintance, and we come to show them our aporeciation eir former kindness. We know of our former welcome we



received in Nashville, and we come the more willingly because of those who have had control of the profession in this city for so many years. It was my privilege to attend lectures under Dr. Buchanan, the man who taught the Science of Surgery, the man who made us efficient to meet the emergencies that came up during our official life. We come here the more willingly because we know we are in the hearts of these people, and especially these ladies. We are proud to know that not only the sons of the Confederacy, but also the daughters, will instill into the minds of the generations to come the deeds that have been wrought by our people. We come the more especially, and feel a gratitude, because one man in this town has made a record of the deeds of heroism, and has given us matter for history that otherwise would not have been written. We honor the man who knows and controls the Confederate Veterans for what he is doing for this cause. We feel that in Nashville every home is our home. We feel that we can go nowhere else and receive any more courtesies that would better suit us than are shown by the profession of this city, and especially the ministry of this town. I remember well Bishop Quintard and others, and the minister who welcomes us, and others who have crossed over the river are ready to-day to welcome us to another shore. Now, I want to say to the citizens of Nashville, I want to say to you who have so generously welcomed us, that we appreciate the motives that you have in affording us the treatment we receive. There are expressions of gratitude in our hearts that we can not utter. We want you to know that we appreciate fully every effort that you make the second time to entertain us. We come on that account largely, feeling that we will receive a welcome at your hands. We will probably meet at but few other reunions. It will soon be our duty, it will soon fall to us to near the setting of the sun, and I have no doubt but that these physicians and these surgeons will have clear consciences, and will meet their Master, having performed their duty. We come to-day among you, thanking you kindly for the welcome you have given us.

Dr. Geo. H. Price, of Nashville, Tenn., then made the following remarks:—

*Gentlemen of the Medical Officers' Association of the Army and Navy of the Confederacy:—*

This is an occasion of peculiar interest to me. If there has been ought of labor connected with the arrangements necessary for your meeting in the city of Nashville, I can assure you that that has been a labor of love. Many of the profession in this city were your comrades in arms and in your professional service, rendered during the stirring days in which you wrought and made a history that shall go down to your sons and sons' sons as a most precious heritage. It is almost impossible for me to look into the faces of these men who are assembled here to-day without being overcome with emotion. It was not my good fortune to be of such an age as to have participated with you in the duties and responsibilities which devolved upon you in that most critical time in the history of our country, but as a youth of tender years, I can recall some of the stirring events which were taking place just at that time. I can recall that with the blare of the bugle and the roll of the drum, to the sound of tramping feet and the roar of musketry, to the tramp of the horses, the men wheeled into line in fours, platoons and companies to the strains of "The Girl I Left Behind Me." I can recall some of these things, even though I was of tender years. I shall not forget the day when I saw pass down the hill towards the railroad station a company of men, composing what was known as the Tuskegee Light Infantry. A gallant set of men, I know they were. How do I know it, gentlemen? Because of all that number but few came back. I heard them as they went. I saw them as they followed the flag. I heard the fife and the drum as down hill they went, playing the "Bonnie Blue Flag," and even though I was a youth of very tender years, my heart went out for the men who that day left the town never to return. The duties which you performed, my brothers of the profession, were no less arduous, no less dangerous, no less heroic than those of the men who carried the gun and followed the flag. In every battle, upon every battlefield, in every hospital, you were the men who stood day and night and ministered to the wants of those who had fallen at the front, and perhaps I look this day

into the face of some man who bent, with tender touch and tender heart, as he looked for the last time and caught the last word of some one who was near and dear to me. Those scenes crowd back upon the memories of these men here. Those times which tried your souls and gave to the world an exemplification of manhood, of bravery, of courage, the like of which has not been seen, are days which shall forever be blessed days, though they were trying days.

Gentlemen, it is with peculiar interest that I welcome you on behalf of the Academy of Medicine, and especially the medical profession of the city of Nashville. Perhaps we shall not again enjoy this privilege, and I wish to say to you, those of you who have grown gray in the cause which you early espoused, in the heart of every man whom I represent there is a tenderness, and a love, and a respect for every man who wore the gray, and who stood in the forefront of the battle, ready to aid, ready to succor, ready to relieve any one from the highest to the lowest. and with these remarks, gentlemen, I beg leave to make a few announcements and turn over this meeting to your President.

Through the kindness of the University of Tennessee, this hall will be at your disposal every day, and each day at eleven o'clock, in the room above, the ladies will serve a lunch to all present.

The President, Dr. J. R. Gildersleeve, then delivered his *annual address*, which was a very interesting paper on "Chimborazo Hospital," which was received with much appreciation.

*Fellows of The Association of Medical Officers of the Army and Navy of the Confederacy, Ladies and Comrades:*

One year ago we held our meeting in New Orleans, the beautiful Crescent city of our Southland, and through your kindness I was honored by election to your highest office. In accordance with a time-honored custom, it devolves on me to deliver the annual address before your body; but before doing so, let me again express my heartfelt thanks for your kindness in selecting me from the "rank and file," with no special fitness, no claim for extraordinary service rendered, no prominence in the subordinate

rank held, to entitle me to this distinguished honor, and though I feel unworthy of the great trust bestowed on me, I hope, sustained by loved friends and old comrades, to merit at least your approbation in my efforts to discharge the duties of my position, and am indeed most grateful, and feel an honest pride in being so exalted.

My loyalty, zeal, and devotion to the Confederate cause was never in question from the 16th day of April, 1861, when I entered the service a private, to those sad and cruel days when the pall of darkness rested on our furled banners in 1865.

I am here, then, in obedience to your commands, and my effort will be directed to filling as best I can this position of so much trust and responsibility, and happy indeed will I be if I can contribute anything worthy of your consideration in my efforts to preserve for our children and for future generations the historic truths of our branch of the service in the dark days of our struggle for homes, principles, and honor.

I have selected as the subject of my address the most noted and largest military hospital in the annals of history, either ancient or modern, "Chimborazo Hospital," at Richmond, Va., 1862 to 1865, and in connection therewith the commandant and medical director, Surgeon James B. McCaw, his staff and my confreres in other fields of the Confederate service.

East of the city of Richmond, whilom capital of the Confederate States, and separated from the city proper by the historic Bloody Run Creek, is an elevated plateau of nearly forty acres, commanding from its height a grand view. On the south, the river, spanned by many bridges, ships in harbor, Chesterfield and the town of Manchester; on the east, a long stretch of country, cultivated fields, forests, hills, and dales, and the tawny James on its tortuous seaward way; and on the west, the city of Richmond, its churches and spires, the capitol, public buildings, dwellings, and manufactories, the whirling, seething, rushing falls of the river, and beautiful Hollywood, "the city of our dead."

On this high and picturesque point, so well adapted to hospital purposes, in the year 1862, when the Federal troops moved in force on Bull Run, and the real campaign began, General Joseph E. Johnston reported that nine thousand men would have to be

sent back to Richmond for admittance to hospitals before his army could proceed.

That grand old Roman and chief, Surgeon-General S. P. Moore, at once went to see Dr. James B. McCaw, of Richmond (who was not then in the medical service, having enlisted in a cavalry company), and as the result of conference held and at the suggestion of Dr. McCaw, Chimborazo Hill was selected as the most favorable site, and early in 1862 the hospital was opened, and in one week two thousand soldiers were admitted, and in two weeks' time there were in all four thousand.

The Surgeon-General had only twenty-five hundred beds when General Johnston made his report. Work was at once commenced, and one hundred and fifty well-constructed and ventilated buildings were erected, each one hundred feet in length, thirty feet in width, and one story high, though not all built at one time, but as needed to furnish comfortable quarters for the sick and wounded. Five large hospitals or divisions were organized; thirty wards to each division. These dimensions allowed of two rows of cots on each side of central aisle; the capacity of each ward from forty to sixty. The buildings were separated from each other by wide alleys or streets, ample spaces for drives or walks, and a wide street around entire camp or hospital. The hospitals presented the appearance of a large town, imposing and attractive, with its alignment of buildings kept whitened with lime, streets and alleys clean, and with its situation on such an elevated point it commanded a grand, magnificent, and pleasing view of the surrounding country for many miles.

The divisions of this immense hospital were five, or five hospitals in one, and five surgeons, each one of the five in charge of a division; also a number of assistants and acting assistant surgeons (45 to 50), each in charge of several wards or buildings, and subject to surgeons of divisions, and all subject to Surgeon James B. McCaw, in charge or executive head.

With natural drainage, the best conceivable on the east, south, and west; good water supply; five large ice houses; Russian bath houses; cleanliness and excellent system of removal of wastes, the

best treatment, comforts, and results in a military hospital in times of war were secured.

In 1861 there was on what is now known as Chimborazo Park or Hill built one house, owned by a Richard Laughton, and a small office building.

For the purpose of making the hospital an independent institution, the Secretary of War made Chimborazo Hospital an army post. and Dr. McCaw was made commandant; an officer and thirty men were detailed and stationed there, and everything conducted "selon de regles."

As the Commandant Surgeon McCaw was not in the regular army of the Confederacy, the Surgeon-General said: "I do not know what name to give the hospital or its chief." Not wishing to call it a general hospital, at Dr. McCaw's suggestion it was given a distinctive name and called Chimborazo, and Dr. James B. McCaw was made commandant and medical director in chief.

When possession was taken of the hill it was separated from Church Hill on the western side by Bloody Run gully. (After the war a street was built across the ravine connecting the two hills and completing the extension of Broad street.) A large house north of the hospital was occupied as headquarters by the medical directors and chiefs of divisions, with a clerical force.

These five hospitals, or divisions, were organized as far as possible on a State basis; troops from the same State being thrown together and treated and cared for by officers and attendants from their own States.

In addition to the one hundred and fifty buildings, there were one hundred "Sibley tents," in which were put from eight to ten convalescent patients to a tent; these tents were pitched upon the slopes of the hill, presenting a very imposing sight.

Oakwood Cemetery, which up to that time had been comparatively a small grave-yard, was created by the hospital. It was near, suitable, and accessible, and is sacred to the memory of many brave soldiers who gave their lives for our cause. The loyal women of Oakwood Memorial Association erected a beautiful shaft on a grassy mound, midst the graves of the "boys that wore the gray," with the following inscription on the four sides of the base:—

In Memory  
of  
Sixteen Thousand  
Confederate Soldiers  
From Thirteen States.  
Erected by the Ladies  
Oakwood Memorial  
Association, Organized  
May 10, 1866.

Maryland	:	:	The Epitaph of
Virginia	:	:	the Soldier who
North Carolina	:	:	falls with his Coun-
South Carolina	:	:	try is written in the
Tennessee	:	:	Hearts of those who
Arkansas	:	:	love the Right and
Florida	:	:	Honor the Brave.
.....			
Kentucky		Georgia	Texas
		Alabama	
		Mississippi	
		Louisiana	

As soon as the hospital was opened, the large tobacco factories of the Grants, Mayos, and others were secured, their business being practically at an end for the period of the war, and the boilers from these factories were utilized in making soup in the soup houses, and the large supply of splendidly seasoned wood, used in making tobacco boxes, was fashioned into beds and other furniture. The hands employed in factories were put to work in doing manual labor, incident to building, etc., in our hospital construction. A guard house was erected separate from other buildings, for unruly convalescents, attendants, et als, and sometimes in use. In addition, the hospital built five soup houses, a bakery, a brewery, and five ice houses

Mr. Franklin Stearns lent the hospital his celebrated farm, "Tree Hill," for the pasturage for from one hundred to two hundred cows, and from three to five hundred goats. The latter

proved to be the best subsistence we had in supplying the hospital with "kid" meat, a most palatable and nutritious food for sick and convalescent patients. Some idea of the dimensions of the bakery may be found from the fact that from seven thousand to ten thousand loaves were issued per diem, a loaf per man, and attendant would not go around.

Soap was made out of grease taken from the soup houses; the lye was imported through the blockade.

An additional fact, the hospital never drew fifty dollars from the Confederate States Government; but relied solely upon the money received from commutation of rations. The medical departments and subsistence departments were organized all to themselves, and the money from commuted rations was used to buy what was necessary.

The hospital trading canal boat, "Chimborazo," Lawrence Lottier in command, plied between Richmond, Lynchburg, and Lexington, bartering cotton, yarn, shoes, etc., for provisions. This was only one of the hospital's many resources.

At the close of the war, the Confederate Government owed the hospital three hundred thousand dollars, which Mr. Memminger, Secretary of Confederate States Treasury, agreed to pay in gold on the 29th of March, and on the 3rd of April the city of Richmond was surrendered.

I now call your special attention to the fact that the total number of patients received and treated at Chimborazo Hospital amounted to seventy-six thousand (out of this number about 17,000 were wounded soldiers), and that it was the first military hospital in point of size in this country and in the world, the next largest hospital in this country being the "Lincoln," at Washington, D. C., which reported a total number of forty-six thousand patients; and the next largest in the world at large was the Scutari Hospital, in the Crimea, which reported a total of thirty thousand to forty thousand patients. The percentage of deaths at Chimborazo was a fraction over nine per cent. Complete records were kept, and are still in existence in the office of the Surgeon-General at Washington, D. C., upon which the name of every patient can be found when wanted, and the cause of his death.



The organization of Chimborazo Hospital: Surgeon, James B. McCaw, commandant and medical director.

First Division, Virginia — Surgeon P. F. Brown, of Accomac, Va., in charge.

Second Division, Georgia — Surgeon Habersham, of Atlanta, Ga., in charge.

Third Division, North Carolina — Surgeon E. Harvey Smith in charge.

Fourth Division, Alabama — Surgeon S. N. Davis in charge.

Fifth Division, South Carolina — Surgeon E. M. Seabrook, Charleston, S. C., in charge.

The medical staff numbered, or averaged, about forty or forty-five in all.

There was also a Medical Examining Board, composed of the surgeons of divisions, to pass on questions of furloughs and discharges. The subjoined roster is not complete, but includes some who are alive and still in active work:—

First Division — Assistant Surgeon George Ross, of Richmond, Va., Assistant Medical Director A. P. Hill Corps: Vice-President Nat. Ass. R. R. Surgeons, etc.; commanded company of University students, April, 1861, at Harper's Ferry. In active practice.

First Division — Assistant Surgeon James C. Watson, of Richmond, Va. In charge First Division at surrender. Ex-Surgeon to State Penitentiary, etc. In active work.

First Division — Assistant Surgeon John G. Trevillian, of Richmond, Va. In active work.

First Division — Assistant Surgeon Dr. J. Prosser Harrison, of Richmond, Va. In active work.

First Division — Assistant Surgeon George F. Alsop.

First Division — Assistant Surgeon W. H. Pugh.

First Division — Assistant Surgeon John G. Baylor, of Norfolk, Va.

First Division — Assistant Surgeon ——— Board.

First Division — Assistant Surgeon ——— Woodson, of Virginia.

First Division — Assistant Surgeon Samuel Smith, of Farmville, Va.

First Division — Acting Assistant Surgeon J. R. Gildersleeve, Richmond, Va.

Second Division — Assistant Surgeon H. Cabell Tabb, of Richmond, Va. Medical Director L. I. Co., of Virginia; Ex-president Medical Directors Association of U. S., Canada, etc.

Second Division — Assistant Surgeon Edward Adams, Amelia County, Virginia.

Second Division — Assistant Surgeon J. C. Vaiden, New Kent County, Virginia.

Second Division — Assistant Surgeon Jack Harrison, Bremon County, Virginia.

Second Division — Steward in charge dispensary, Joseph A. Lee, now chief surgeon Norfolk and Western R. R., and President Medical Society of Virginia 1903 - 1904.

Third and Fourth Divisions — Assistant Surgeon John Mabry, South Carolina; Assistant Surgeon Shirley Carter, Virginia; Assistant Surgeon ——— Field; Assistant Surgeon ——— Elderby; Assistant Surgeon ——— Chapman; Assistant Surgeon ——— Wall, Florida; Assistant Surgeon Edward Wiley; Assistant Surgeon ——— Stratton.

Fifth Division — Assistant Surgeon W. B. Gray, of Richmond, Va. Ex-Vice-President Medical Society of Virginia, Richmond Academy of Medicine, Richmond Microscopic Society, etc. In active work.

Fifth Division — Assistant Surgeon Charles Lee Dunkly.

Fifth Division — Assistant Surgeon William A. Hardee.

Fifth Division — Assistant Surgeon C. Jerome Cherry, of Portsmouth, Va.

Fifth Division — Assistant Surgeon ——— Moss.

Fifth Division — Assistant Surgeon ——— White, of Portsmouth, Va.

Fifth Division — Acting Assistant Surgeon J. R. Gildersleeve, Richmond, Va.

Fifth Division — Apothecaries, Jett T. West and Sursdorff, North Carolina.

Among the staff were the following named gentlemen: John Claiborne, commissary; Col. A. S. Buford, quartermaster; Pine and Kent, our commission merchants, and many others.

Every man did his whole duty, and everything went on without a hitch. The total staff, one hundred and twenty.

Mrs. Dr. Minge was chief matron. There were many interesting characters among the matrons, and one in particular was Miss Mary Pettigrew, who was chief of the Virginia Division. She was a sister of General Pettigrew, of North Carolina, and was about twenty years of age. Also a Mrs. Pender, Mrs. Baylor, Miss Gordon, et als—forty-five in all. Rev. Mr. Patterson, a Greek by birth, was chaplain; he came to this country when a grown man, and was a very valuable officer.

The city of Richmond was surrendered Monday, April 3, 1865; General Weitzel's brigade in the van of the advancing Federal army. The general rode up the hill, and when he came through the post he was received by our whole corps of officers in full uniform. Dr. Alexander Mott, chief medical director of the staff of General Weitzel, exclaimed: "Ain't that old Jim McCaw?" "Yes!" said Dr. McCaw, "And don't you want a drink?" Mott's answer was, "yes," and he added, "the General will take one too, if you will ask him." The invitation was duly extended and accepted. Dr. McCaw asked General Weitzel for a general permit for him and his officers; this was promptly granted. General Goedfrey Weitzel gave a free pass to the commandant and his entire medical corps, took them under his protection, and issued a verbal order that all Confederate soldiers there should be taken care of under all circumstances. Furthermore, he offered to put the commandant in the general service of the United States, so that he might issue requisitions, etc., and have the same filled as any other medical director in the United States army. As General Lee had not then surrendered, Dr. McCaw respectfully declined the proffered appointment, but voluntarily continued to perform all the duties incident to the position he held, and never solicited anything at all from them other than the passes in and out of the lines.

When we consider the size of this great military hospital, the number of soldiers admitted, treated, furloughed, discharged, and buried; its successful work for nearly four years; the perfect discipline, order, and harmony that existed from its establishment to its close; the immense amount of work done; the difficulties

always attending the securing of supplies for such a large body of invalids, especially towards the closing days of the Confederacy, and also the generous rivalry between other posts or hospitals located in Richmond; and lastly, the comparatively low mortality, we cannot but accord to Dr. James McCaw, medical director of the five Chimborazo hospitals, and its efficient commandant, the highest praise, and concede that he was in fact and in deed "*primus inter pares*." It is my greatest pleasure to offer this tribute to my chief, and to one of the grandest men in our profession, for he is still with us, though an octogenarian. "*Clarum et venerabile nomen*." Towering physically and mentally above his associates, and quoting from one of his admirers: "Princely Dr. James B. McCaw, sweet, gentle, tender, and true," and I shall add, "brave, generous, and loyal; just honorable, and upright, an exemplar worthy of emulation." Teacher, philosopher, scientist, editor, and physician, over sixty years devoted to the acquisition of knowledge and disseminating the truth as acquired to his beloved pupils in class and lecture rooms; a magnificent physique, graceful and polished in manner, with a great amount of personal magnetism; in speech, clear, happy in illustration, chaste, humorous, and pathetic, sometimes epigrammatic, a boon comrade around the social board, an ardent admirer of the beautiful, together with high, cultivated, artistic taste. His masterly handling as editor of advances in all branches of medicine, editorials, reviews, and original articles, the midnight research and investigations in new scientific fields, his active professional life for six decades as surgeon, obstetrician, and in general practice of medicine in a large, wealthy, and exacting private practice, is in itself a proof of the high estimation in which he was held. Such a grand, noble, and self-sacrificing nature, so optimistic, sunshiny, and happy is seldom seen blended in one man. A beautiful loving cup was presented to him in 1901 at a banquet given by the Academy of Medicine of Richmond and friends on his retirement after fifty-seven years from the active practice of medicine, in honor of this nestor of the profession. In responding to toast from Dr. George Ross, toastmaster, Dr. George Ben Johnson, of the Medical College of Virginia, said: "This event has a greater significance to me than the gathering

of a multitude to welcome a victorious general; Dr. McCaw has always been my example." Dr. J. Allison Hodges, of North Carolina, said: "The grandest sight I have ever witnessed is the sight of a noble and beautiful life, wrapping itself around the destinies of the sick and suffering children of men, and finding its blessed reward in the benediction of everlasting love and peace; and such a sight I have witnessed displayed in the long and honorable life of my friend, Dr. McCaw."

Dr. James B. McCaw was born in Richmond, Va., July 1, 1823. Graduated M. D. University of the City of New York 1844. Editor Virginia Medical and Surgical Journal 1853 to 1861. Editor of Confederate States Medical and Surgical Journal from 1861 to 1865. Professor of Practice of Medicine and of Chemistry, and Dean of the Medical College of Virginia twenty-eight years. Now Emeritus Professor, Surgeon U. S. Army. Medical Director during civil war of the five Chimborazo hospitals Richmond, Va. A charter member and one of the founders of the Medical Society of Virginia, and chairman of the Convention which organized the Society in 1870; Vice-President in 1871. Resident Honorary Fellow in 1894. Ex-President of the Academy of Medicine, Richmond, Va. Honorary member of the Medical Society of West Virginia. Member of the Medical Association of Medical Officers of the Navy and Army of the Confederacy, and of other Societies.

Fellows and comrades, you will, I hope, pardon me if for brief space I become personal. My object is simply to preserve in regular order and to perpetuate the names and positions held by my most intimate associates in the medical service of the Confederate army, and, if time permitted, it would have been a pleasant task to present in this paper biographical sketches of each friend and associate herein mentioned.

My first hospital service dates from 1862; after my discharge from the service, on account of illness, I was then a private in the Richmond Howitzers. I entered hospital "Midway" between the University of Virginia and Charlottesville, Drs. James Cabell, John Staige Davis, B. W. Allen, Peter Winston and others in control: the first three were professors at the University of Virginia. Dr. Cabell, surgeon in charge, was a man of pr

found knowledge and varied information, and a fine executive officer; it was said of him that he could fill creditably any chair at the University. Dr. Davis had a Southern reputation as a brilliant and beautiful lecturer. Dr. Allen an anatomist and skilful surgeon. Dr. Peter Winston left his studies in Paris and returned at the commencement of hostilities, and at once entered our service. My connection with hospital was brief, but long enough to retain in my heart the warmest feelings for each one of my associates.

The exigencies of the service demanded all who could administer to the sick and wounded of the army, and I received an appointment as contract physician—i. e., acting assistant surgeon—July 8, 1862, from Surgeon-General Samuel P. Moore. The name of that grand head of the medical departments of the Confederacy impels me to acknowledge his kindness of heart to all of his subalterns; also his great work as an organizer, his remarkable executive ability, fitness for the high position, and his official work. Resigning his position of surgeon in the United States Army, he was appointed Surgeon-General of the army and navy of the Confederacy June, 1861, and continued in office until the surrender; then in practice in Richmond, Va., until his death. Born in Charleston, S. C., in 1813, died in Richmond, Va., May 31, 1889. President of the Association of Medical and Surgical Officers of the Army and Navy of the Confederate States, at Atlanta, Ga., May 25, 1874.

I was assigned on my appointment to duty at Howards Grove Hospital, Richmond, Va., Dr. James Bolton, surgeon in charge. The tents and buildings were crowded with wounded soldiers from battle fields after seven days' fight below Richmond. Dr. C. D. Rice, of Charleston, S. C., succeeded Surgeon Bolton, and I was ordered to receiving and distributing hospital No. 9, "Seabrooks Warehouse," twelve hundred beds, Surgeon C. W. P. Brock in charge. Assistant Surgeons John Gravatt, Port Royal, Va., J. W. Brock, Richmond, Va.,——— Richardson, Texas. John Bragg, Petersburg, et als. Dr. C. W. P. Brock, one of the youngest men in the profession, and now chief surgeon of the Chesapeake and Ohio Railroad. Ex-Pres. Nat. Ass. R. R. Sur-

geons, 1893. Ex-Pres. Ass. Alumni Med. College of Va., and has held many other positions of honor and trust.

I was then ordered to Chimborazo Hospital, after a short service at No. 9, and assigned to Division 5, "South Carolina;" afterwards to Virginia, Division No. 1, and remained until January, 1864. Ordered to appear before Army Medical Board, composed of Surgeons Gedding, Holbrook, and Robertson, in Charleston, S. C. Passed successfully examination January 15, 1864, and was commissioned assistant surgeon Confederate States Army, and ordered to report to Medical Director J. D. S. Cullen, of Lieut.-General Longstreet's Corps, at Knoxville, Tenn. Reported to Surgeon Maury, in absence of medical director, and was ordered by him to report to Medical Director Frank A. Ramsey, of the Army of Tennessee, and by him ordered to report to Surgeon R. D. Hamilton, Bristol, Tenn. A short time there in charge, temporarily of Wayside Hospital, and in hospital at Abingdon, Va., under Surgeon R. O. Curry, then in charge of transportation of sick and wounded from General Longstreet's army to hospitals along line of railroads in Virginia.

On General Longstreet's return to Army of Northern Virginia, was assigned to Kershaw's Brigade, and from Wilderness to surrender with Twentieth South Carolina Regiment (a short time with Seventh South Carolina). On retreat from Charleston, S. C., of General Joseph E. Johnston's army was captured at Fayetteville, N. C. Was paroled 13th day of May, 1865, at Charlotte, N. C., by Captain N. Haight, U. S. Army.

The medical staff of General Kershaw's Brigade, afterwards General Connor's Brigade, Dr. James, Brigade's Surgeon:—

Second South Carolina Regiment—Surgeon Simon Baruch, now of New York, and well known in connection with hydrotherapy. Assistant Surgeon Nott.

Third South Carolina Regiment—Surgeon James Evans, Assistant Surgeon Dunlap, Assistant Surgeon Mackie

Seventh South Carolina Regiment—Surgeon Carlyle, Assistant Surgeon J. R. Gildersleeve.

Eighth South Carolina Regiment—Surgeon Pearce, Assistant Surgeon Neal, Assistant Surgeon Speake.

Twentieth South Carolina Regiment—Surgeon A. S. Sally, Assistant Surgeon, D. W. Bartron, Assistant Surgeon, J. R. Gildersleeve.

Dr. Sally was a highly educated gentleman of the old school, honest, upright, and pure. A writer and local historian.

My roster would be incomplete if I omitted that grand and venerable bishop, William W. Duncan, of the Methodist Episcopal Church, South, who was chaplain of the Twentieth South Carolina Regiment.

Of the many who were my confreres in the different fields of service, a number have since achieved State and national reputations, due, in a great measure, I believe, to the stern lessons inculcated whilst participants in the bloody drama enacted more than four decades ago, which were potent factors, developing in the subsequent battles of life a courageous bearing, a self-reliant aggressiveness and progressiveness, ultimately leading to success—from defeat to victory.

I was indeed fortunate in my associations, and the kindness, counsel and encouragement extended me from one and all made an indelible impression, and proved formative influences in my future life. For all of my dear comrades, alive or dead, in the deepest recesses of my heart there is love.

But inexorable and mysterious death, with relentless hand, has been busy, and is fast thinning out the few remaining comrades in our ranks, a reminder to those of us who are still living that—

“Each day a leaf falls withered from the tree  
Whose leaves make up the life of thee and me;  
The leaves are counted and the last is there  
Ready to fall before thy destiny.”

“Where are the dear old faces gone a-hiding.  
Where is the far-off place of their a-biding?  
I ask the Wise, and thus the Wise to me,  
They are gone, and there is never a-tiding.”

Let us hope, fellows and comrades—

“That somewhere at life's journey's end  
Friend will again behold the face of friend.”



At its conclusion, Dr. J. B. Cowan moved that the paper be received and filed in the archives of the Southern Confederacy in New Orleans. Seconded and carried.

The unanimous thanks of the Association were then tendered Dr. Gildersleeve by a rising vote.

The meeting then adjourned until 9 o'clock, Wednesday morning, June 15.

*(To be continued in September number.)*

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## **Editorial.**

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### FOOD PRESERVATIVES.

The following article which we reproduce in full appeared in the *Nashville Daily American* of July 21st.

"In a sample of sausage obtained from a meat and sausage dealer of this city by City Food Inspector Blaine Danley, F. W. Smithers, of the firm of Lucius P. Brown & Co., analytical chemists, found four grains of sodium sulphite, equivalent to two grains of sulphurous acid, to the pound. For some time Food Inspector Danley has been quietly gathering data relative to the use of preservatives by local meat dealers. After making an extensive investigation, Mr. Danley says there is not a butcher in Nashville who does not use some sort of chemical preservative, some of which are more injurious than others.

One of the most common preservatives used is a preparation called "freeze 'em," manufactured by — — — & Co., of Chicago. It was this preservative that was found in the sausage, a sample of which was furnished to Mr. Smithers. Mr. Smithers also analyzed a sample of "freeze 'em" submitted to him by Mr. Danley, and, it is said, found that it contained 78.86 per cent. of sodium sulphite, equivalent to 40.06 per cent. of sulphurous acid. It also contained a small amount of sodium chloride and sodium carbonate, both of which are comparatively harmless.

The sodium sulphite, which is the preservative ingredient of the compound, is considered by physicians very deleterious. The percentage of this ingredient which the sample of "freeze 'em" analyzed by Mr. Smithers contained was regarded by him as very large, considerably exceeding the percentage of it found in a sample analyzed at the Connecticut Agricultural Experiment Station in 1899. This sample contained only 57.48 per cent. of sodium sulphite.

"Freeze 'em" is a flesh-colored powder, the presence of which in meat and sausage it is impossible to detect except by means of chemical

analysis. Its preservative powers are very great, as was illustrated by the sample of sausage containing it furnished by Inspector Danley to Mr. Smithers. Although the latter kept the sample without refrigeration for six or seven days it did not spoil. Indeed, it appeared almost as fresh on the last day as when it was delivered to him.

All the butchers in the city use some sort of preservative, Mr. Danley says, and what may be especially surprising to the public, use it without measuring it.

Preservatives, the Inspector said, were used most largely in sausage, but they were also used to a considerable extent on all kinds of fresh meat, and on game, poultry, and fish by local meat and fish dealers.

Preservatives in meat have produced very serious results. Mr. Smithers has a pamphlet reciting a number of instances of persons having been made seriously ill by preservatives. Dr. Larkin Smith, City Health Officer, who has been taking much interest in Mr. Danley's investigation, said Wednesday that preservatives, such as sodium sulphite and formaldehyde, taken into the stomach day after day, even in very small quantities at a time, might exert a very deleterious influence.

At present there is no law, either State or municipal, prohibiting or restricting the use of preservatives in foods, but it is believed that when the public becomes acquainted with the manner in which they are used and the fact that they are generally used by meat dealers, there will be a very general demand for legislative action to prevent the use or abuse of preservatives."

While those of our readers in the city of Nashville and vicinity who read the *American* may have noticed the article above quoted, yet quite a number may find it *news* of rather a startling and somewhat unpleasant and unappetizing character.

As to there being "no law, either State or municipal, prohibiting or restricting the use of preservatives in foods," we beg leave to differ. We have proper municipal enactment for the sale of unwholesome food-stuffs, and it is, in our opinion, as much the province of the City Food Inspectors to protect our citizens from imposition and injury by food rendered unwholesome by means of chemicals as by other causes. While it is possible there may not result anything in the line of poisoning from the use of such chemicals, such food is not proper material for nourishing the human economy.

The sulphite of sodium is occasionally used internally in doses of v-xxx grs., up to lx grs, as an antizymotic and antiseptic in fevers, on theoretical grounds that have not been satisfactorily realized, yet this is no reason why the dealers in fresh meats should resort to this or any other drug for preventing the natural decomposition of animal matter during the hot season. The action of sodium sulphite when taken into the stomach, is to give off the sulphurous acid which has a great affinity for oxygen and is very destructive to cell life. The sulphate of soda left may, if in sufficient quantity, act as a purgative; and although these

chemicals may be administered at certain times, and for some length of time medicinally, this is quite different from being used in uncertain and unknown quantities day by day in, and as a part of the food taken to sustain the body.

Outside of the chemical effect, there is another point which brings such so-called food under the ban of municipal enactment. Digestion is a process closely allied to decomposition. It is a breaking up of an organic compound into its constituents, so that it may become absorbable. If decomposition can be arrested by a given chemical action, so can digestion, hence, foods having such preservatives applied cease to be foods. No nutrition is available therefrom. The man who purchases such is not only swindled, but his digestive organs and his tissues are also swindled. Such food is just as much unwholesome and unfitted to maintain life as foods that are immature, over-ripe, or in a stage of decomposition. Our food inspectors are commissioned and salaried for the express purpose of preventing the sale of unsound and *unwholesome* food stuffs. If such an officer can arrest a milk man in the event his supply of lacteal fluid does not come up to a certain standard, it is just as much his duty to prevent the imposition on our citizens of such meat as has been deprived of its qualities as a food and its necessary elements of nutrition.

However, in the event the law is not enforced as to this, we have yet another recourse. In fact we eat too much fresh meat in the hot summer months. Nature does not intend that we should be as cannibalistic in the summer season as she permits in the winter. Hence, she provides an innumerable array of fruits and vegetables for our sustenance in the hot weather, and adds the additional precaution of causing all fresh meat to rapidly become unfit for food; and it is a mistake upon the commercial enterprise of the country to undertake to fly in the face of Nature's laws. Even cold storage meats, which are possibly about the least harmful, are not as wholesome, nor are they as nutritious as the same meat that has not been submitted to even this process. Yes, if we will follow more after the apparent teachings of Nature, live largely on fruits and vegetables, supplemented by eggs, milk, and occasionally a little good bacon, preserved as "our mothers" preserved it with sodium chloride, potassium nitrate, and corn-cob or green hickory smoke properly applied in the proper season, we will get along far better than on even cold storage meats, to say nothing of that rendered wholly unfit for nutrition by chemicals and drugs.

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ANDERSON'S CAPSULES for the introduction of medicated cotton into the vagina are very convenient, answering the purpose perfectly, avoiding discharge of the medicament from the cotton during introduction, a matter of no little annoyance both to patient and physician.

## THE TREATMENT OF SUMMER DIARRHŒA.

In the treatment of any form of diarrhœa an accurate diagnosis must first be made. For convenience it is customary to classify diarrhœas somewhat after this fashion: 1. Diarrhœa of relaxation, or serous diarrhœa, due to disordered innervation; 2. Crapulous or lenteric diarrhœa, due to imperfect digestion; 3. Catarrhal diarrhœa, acute or chronic; and 4, Ulcerative diarrhœa, due to intestinal ulceration.

This classification is by no means perfect as is shown by the multiplicity of terms applied to the various pathologic states characterized by diarrhœa. Thus we have the terms acute inflammatory diarrhœa, acute summer diarrhœa, choleraic diarrhœa, dysenteric diarrhœa, nervous diarrhœa, tuberculous diarrhœa, etc. In each case the diagnosis is determined by the actual condition prevailing, of which the intestinal laxity is usually but a prominent symptom.

The question of treatment is one of the utmost importance. Without entering into a discussion of what soon proves to be a very broad subject, it may be worth our while to consider briefly the status of the antiseptic method of treating intestinal disorders, especially those caused by pathologic organisms and of which diarrhœa is the chief symptom. Apart from well-directed efforts to clear the intestine of bacteria, reduce the temperature, sustain the vitality of the patient, regulate the diet, secure proper hygienic conditions, rest, and good care, the selection of the proper antiseptic agent demands the exercise of the physician's best judgment.

Whether or not it be possible to attain intestinal asepsis is of course a debatable question, but it is a well-established clinical fact that intestinal antiseptics do good and modify the course of enteric diseases of bacterial origin, notably typhoid fever, dysentery and summer diarrhœa. However, there is a difference in the degree of efficiency of the various antiseptics, the utility of many being limited by the risk of untoward action from excessive dosage. In those cases of ileo-colitis caused by the bacillus of Shiga many of the serious symptoms are due to a mixed infection, to combat which prompt and vigorous measures are required.

The experiments of Novy and Freer (*Contributions to Medical Research*, p. 114) with benzoyl-acetyl-peroxide (Acetozone) showed that this substance is extremely germicidal to the organisms found in the alimentary canal. Its administration to rabbits resulted in the "practical sterilization of the contents of the stomach." In several experiments with these animals "the intestinal tract apart from the cecal pouch, was found to be sterile." Neither bouillon tubes nor agar showed growths, though the controls gave abundant cultures. Other experiments showed that enzymes and toxins are also destroyed or rendered inert by Acetozone. Further study demonstrated not only the remarkable germicidal power of Acetozone, but also the fact that its aqueous solutions may be given internally, and even injected intravenously, without harm. From these data we infer that this substance ranks among the most powerful germi-

cidal agents, while it exerts no harmful effect upon the human organism and may, therefore, be employed as a therapeutic agent in the treatment of summer diarrhoea and other infectious enteric diseases with the best effect. There seems to be abundant evidence to warrant the suggestion that Acetozone solution should prove most valuable in colonic flushing, as it is entirely free from the danger that attends the use of large quantities of even weak solution of mercuric chloride, and for that reason may be used fearlessly.

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### HAY FEVER.

For a number of years the malady known as hay fever has been the theme of many an able discussion. Its etiology, pathology, prophylaxis and treatment often have been the subject of study and experiment by physicians, and also by intelligent laymen. The disease has been described as a catarrhal affection of the conjunctivæ and the mucous membrane of the respiratory tract, characterized by an annual recurrence at about the same date in a given case. Another view is that the disease is a neurosis, and that the local symptoms (rhinorrhœa, sensory disturbances, etc.) are due to vaso-motor paralysis.

The most conspicuous symptoms of hay fever are a burning and itching sensation in the nasal region and between the eyes; violent paroxysms of sneezing; a copious discharge of serum and liquid mucus from the nasal passages; profuse lachrymation; now and then febrile manifestations; frontal headache, and in not a few cases, some asthma.

The diagnosis having been established the subject of prevention and treatment is of the utmost importance. It would be utterly useless and wearisome to attempt to review the list of remedies and the methods of treatment that have been proposed for this disorder. The interests of physicians and patients will best be served by a recital of facts respecting the most successful mode of treatment known at this time.

A glance at the list of symptoms and a brief consideration of the pathology in hay fever lead to the immediate conclusion that the chief indications are to check the discharge, allay the irritation that gives rise to the paroxysms of sneezing, reduce the turgescence of the nasal mucosa, and relieve the stenosis. The only single remedy that meets these indications is Solution Adrenalin Chloride and Adrenalin Inhalant. By stimulating the vaso-motor supply it contracts the arterioles, and thus promptly and efficiently relieves all the annoying symptoms referable to vaso-motor paralysis. By its powerful astringent action upon the mucous membrane, which it blanches completely in a few moments, it controls symptoms referable to a catarrhal inflammation of that structure. Indeed the results that have been accomplished with Adrenalin in this field alone are really remarkable and of the utmost importance. Parke, Davis & Co., who market Solution Adrenalin Chloride and Adrenalin Inhalant, have pre-

pared a very complete treatise on the topic, which contains more information than is to be found in the average text-book. They will cheerfully mail a copy of the booklet to any physician applying for it

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**NEUROTIC CONDITIONS IN WOMEN.** Prof. Chas. J. Vaughan Chair of Gynæcology, Atlanta College of Physicians and Surgeons, writes: "Neuralgia constitutes the great cause of danger from the employment of hypnotics and narcotics, which only afford relief by numbing, but effect no cure. On the other hand, the formation of a drug habit rather aggravates the condition from which relief was originally sought. Neurasthenia, neuralgia, and other manifestations, either of an active or passive character, are common and are always peculiarly rebellious to treatment. Cerebro-nervous affections peculiar to women associated with pathological disturbances of the reproductive organs are legion, and most trying to physician and patient. I have found nothing so well suited to these cases as Antikamnia Tablets, administered in doses of from one to three tablets and repeated every one, two, or three hours according to the attendant's judgment. These tablets afford complete relief without fostering a drug habit and their exhibition is attended with no unpleasant after-effects. For the relief of painful menstruation there is no combination of remedies so generally successful as Antikamnia and Codeine Tablets. Their sedative, analgesic, and anodyne properties especially commend them in the neuralgic and congestive forms of this distressing affection."

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**BRAINFAG**, from worry, overwork, or excesses of various kinds, is quickly relieved by the use of celerina, in teaspoonful doses three times a day.

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**MISSISSIPPI VALLEY MEDICAL ASSOCIATION.** The Thirteenth Annual Session of this Association will be held at Cincinnati, Ohio, October 11, 12, 13, 1904, under the presidency of Dr. Hugh T. Patrick of Chicago. The headquarters and meeting places will be at the Grand Hotel.

The annual orations will be delivered by Dr. Wm. J. Mayo, of Rochester, Minn., in Surgery, and Dr. C. Travis Drennen, of Hot Springs, Ark., in Medicine.

Request for places upon the program, or information in regard to the meeting, can be had by addressing the Secretary, Dr. Henry Enos Tuley, Louisville, Ky., or the Ass't Secretary, Dr. S. C. Stanton, Masonic Temple, Chicago, Ill.

The usual railroad rates will be in effect.

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**A POINTER.** Although Mellin's Food is used to modify fresh cow's milk for the well child, it may, when milk is temporarily contraindicated, be used with water alone, with whey alone, with whey and water, or with

egg and water. Used in any one of these ways, and given either hot or cold, in small amounts frequently repeated, it serves to supply the baby patient with nourishment in a form which will be easily digested and which will not set up any intestinal irritation. Mellin's Food is free from starch. During the process of manufacture the insoluble starch of the grains is converted into soluble maltose and dextrine. Mellin's Food is therefore much to be preferred to decoctions of barley, wheat, rice, or oat flours.

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**COCA A CARDIAC TONIC.** Coca has been advocated by a number of observers to tone up the heart muscle. It may be employed as Vin Mariani in conjunction with the above-mentioned remedies or used alone. A unique action of Coca which renders it peculiarly fitted to the role of a heart tonic is the depurative influence it has upon the blood stream, thus enabling the muscular structure to take up the pabulum which shall give it strength. Coca is useful following a course of digitalis, and in irritable heart there is probably no better remedy.—*The Coca Leaf*, November, 1903.

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**WAYNE'S DIURETIC ELIXIR.** For twenty-five years we have been using this special compound of buchu, juniper, acetate of potash, etc., with the most gratifying results. In all cases of renal or vesical irritation, from whatever cause, it has been fully as definite in satisfactory and agreeable results as any pharmaceutical preparation in other conditions. A number of specialists of the highest standing, and many general practitioners in our personal knowledge have found it equally reliable. Only two requests are made by its manufacturers; viz, *Try it; and allow no SUBSTITUTES.*

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**BRUISES, SPRAINS, AND ABRASIONS** consequent upon tennis, golf, mountain climbing, and other out door sports are prevalent at this season. Infected wounds are frequent and disabling. Country life also brings the results of contact with poison-ivy, poison-oak, and the various venomous insects with their characteristic weapons of offense. In all these cases the physician's first thought should be Antiphlogistine. It reduces inflammation of all sorts better and more quickly than any other application, while for poisoned wounds and dermatitis venenata it is almost a specific.

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**NEW ORLEANS POLYCLINIC:**—*Eighteenth Annual Session opens November 7, 1904, and closes May 20, 1905.* Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory and cadaveric work.

For further information address, New Orleans Polyclinic, Post-office box 797, New Orleans, La.

## *Reviews and Book Notices.*

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PROGRESSIVE MEDICINE, Vol. II, June 1904. A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 334 pages, 47 illustrations. Per annum, in four cloth-bound volumes, \$9.00; in paper binding, \$6.00, carriage paid to any address. Lea Brothers & Co., Publishers, Philadelphia and New York.

The June issue contains four sub-divisions: Surgery, gynecology, medicine and ophthalmology. Each of these articles, which together cover the major domain of modern medicine, is from the pen of an authority especially selected for the qualities which the task preeminently requires — experience, trained judgment and critical acumen. The aim of the authors has not been to summarize *all* that has been written within the sphere of their respective subjects: their purpose is to give the best, the most reliable, the truly progressive contributions to modern theory and practice, and to skillfully weld this new material into the great structure of modern medicine,

The work is issued in paper binding at \$1.50 per vol.; in cloth at \$2.25.

AMERICAN EDITION OF NOTHNAGEL'S PRACTICE: TUBERCULOSIS AND ACUTE GENERAL MILIARY TUBERCULOSIS, by Dr. G. Cornet, of Berlin. Edited, with additions, by Walter B. James, M. D., Professor of the Practice of Medicine in the College of Physicians and Surgeons (Columbia University), New York. Handsome octavo volume of 806 pages. Cloth, \$5.00; Half Morocco, \$6.00 net. W. B. Saunders & Company, 1904. Philadelphia, New York, and London.

This is the seventh volume to be issued in Saunders' American edition of Nothnagel's Practice, and the remaining four volumes are in active preparation for early publication.

The American edition of Professor Cornet's exhaustive work appears at a time when the subject of tuberculosis has a peculiar claim upon the attention of mankind. Within a few years both professional and general public interest in the disease has taken



enormous strides. In almost every civilized community societies for the prevention of tuberculosis are being organized, and these are composed not only of physicians but of laymen, while governments themselves are taking an active part in the movement. Under these circumstances, and at this time, the work is of interest to practitioners, for there is no other treatise which gives an equally clear and comprehensive view of this subject.

The article on acute general miliary tuberculosis has been admirably written and gives a thoroughly clear understanding of this disease.

The importance of the chemistry of the tubercle bacillus and its bearing upon immunity have warranted a thorough treatment of this subject.

The work is complete and logically arranged, and the editor has made additions where necessary to bring it down to date.

**A REFERENCE HAND-BOOK OF THE MEDICAL SCIENCES**, embracing the entire range of scientific and practical medicine and allied sciences, by various writers. A new edition completely revised and rewritten. Edited by Albert H. Buck, M. D., of New York City. Vol. VIII, pp. 784. Illustrated by chromolithographs and 435 half-tone and wood engravings. Wm. Wood & Co., Publishers, New York, 1904.

At last the eight splendid volumes of this magnificent Reference Hand-Book of Medicine and all that pertains to it are complete. It comprises a full and complete Library in itself, by which one can obtain practical and reliable information on any question touching the broad domain of Medical Science.

This volume begins with "Umbelliferæ," and the subject matter closes with "Zymolysis," comprising 342 pages, and An Appendix, treating of subjects not considered in the preceding volumes, or giving later data occupies the succeeding 258 pages, with a full and complete Index of 184 pages, covering the entire eight volumes, completing Dr. Buck's most valuable addition to the medical and surgical literature of the initial years of the present century.

A large part of the material contained in this Handbook is original work, and, upon some subjects, the information now presented has heretofore been inaccessible, by reason of its being

scattered through governmental and other manuscript records and archives.

This superb work covers so wide a field, and embraces such a large variety of topics, as to make it of the *greatest practical utility*, not only to general practitioners, but also to those who are interested more particularly in special departments of medical knowledge.

The topics are treated in such a thorough manner that the reader will rarely, if ever, find it necessary to consult larger special treatises or monographs for the information of which he may stand in need.

The full list of authors who have contributed to the work aggregates about 500 leading American writers.

The prices of the work are as follows; In extra English muslin, \$7.00 per volume; fine leather, raised bands, \$8.00; and in extra Turkish morocco, English cloth sides, \$9.00 per volume.

PHYSICIAN *versus* BACTERIOLOGIST, by Prof. Dr. O. Rosenbach of Berlin. authorized translation from the German by Dr. Achilles Rose. 8vo. cloth, pp. 642; price \$1.50. Funk and Wagnalls Co., Publishers, 44-60 East 23rd St., New York, N. Y., 1904.

This important book, in which the author aims to place medicine on the rational basis whence, it is declared, bacteriological aberrations have been endeavoring to banish it, is an authorized translation from the German by Dr. Archilles Rose. The translator gives as his reason for presenting the book to his English-speaking colleagues, that they "may learn what an independent and original investigator has said on the great problems of medicine to-day, and what he has written to restore the rights and re-establish the position of the general practitioner, which have been encroached upon by a morbid proliferation of specialism and a one-sided organotherapy." Dr. Rosenbach, as his translator points out, fully appreciates the value of bacteriology as a biological science, and is well aware what surprising information and important methods are to be found in its study, but he aims to overthrow the fallacious conclusions that have been established, that all infectious diseases are caused by bacteria, and that all diseases in which so-called

specific bacteria are found are infectious diseases. The thorough and comprehensive manner in which the author has examined and discussed his subject can not fail to be of very great interest, if not enlightenment, to the medical profession.

**PROGRESSIVE MEDICINE.** A quarterly digest of advances, discoveries, improvements, etc., in the medical and surgical sciences. Edited by Hobart Amory Hare, M. D., Prof. of Therapeutics and Materia Medica in the Jefferson Medical College, etc., assisted by H. R. M. Landis, M. D., Asst. Physician to the Dispensary of the Jefferson Medical College, etc. Vol. VI, No. 1, 8vo paper, pp. 337. Price \$1.50. Lea Bros. & Co., Publishers, Philadelphia, March, 1904.

This excellent number of the splendid quarterly of Messrs. Lea Bros. & Co., contains some valuable articles on Surgery of the Head, Neck, and Thorax; Infectious Diseases, including Acute Rheumatism, Croupous Pneumonia, and Influenza, the Diseases of Children, Laryngology, Rhinology, and Otology.

This volume is especially rich in surgical subjects, although we can but recognize the great value of articles along other lines. Tetanus is fully and ably discussed along the lines of the most recent developments, and the importance of gelatin injections as a cause of the disease, in connection with the Fourth of July blank cartridge, and the value of carbolic acid injections are very ably considered.

Thirty-three cases of epilepsy operated on and reported by Spratling; the results being tabulated are of unusual interest. However, time nor space permit us to particularize, and no one will be in any way disappointed in securing and carefully investigating the valuable material in this volume.

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### *Selections.*

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**THE INFLUENCE OF NURSING UPON THE FREQUENCY OF CARCINOMA OF THE MAMMÆ.**—L. Lehman in a very interesting essay has compiled all the accessible statistics pertaining both to the frequency of carcinoma of the breast and the percentage of mothers nursing their children. These statistics, referring mainly to the conditions in Germany, include, however, a number of other European and foreign countries. A comparison of these

statistics demonstrates the surprising fact that all those countries in which the nursing of the babies by their mothers is notoriously more in vogue show a smaller percentage of mammary cancer. It would seem that hypoplasia of the breast, due to a failure of proper use continued during a generation, forms a predisposing factor in the development of a malignant growth. —*Interstate Medical Journal*.

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ANTITETANIC SERUM.—It has been shown that guinea pigs and other animals inoculated with the poison of tetanus, survive when treated at once with antitetanic serum. In France, Nocard observed 376 animals of various kinds, all of which had been wounded, accidentally or surgically, and subjected to tetanic infection. These animals were given antitetanic serum at once, before the disease had time to develop. As a result, not a single case of tetanus occurred among them. On the other hand, he noted fifty-five traumatized animals that had been exposed to tetanic infection, every one of which developed the disease. —*Alabama Medical Journal*.

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PSALM OF MARRIED LIFE:—

Man that is married to woman is of many days and full of trouble.

In the morning he draweth his salary and in the evening  
Behold it is gone.

It is a tale that is told:

It vanisheth and no one knows whither it goeth.

He riseth up clothed in the chilly garments of the night

And seeketh the somniferous paregoric

Wherewith to sooth his infant posterity.

He cometh as a horse or ox.

And draweth the chariot of his offspring,

He spendeth his shekels in the purchase of fine linen,

To cover the bosom of his family.

Yet himself is seen at the gate of the city with one suspender.

Yea! he is altogether wretched.

*Valpariso News.*

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Bismuthi subnit..... gr. lxxx

Morphinæ hydrochlor..... gr.  $\frac{1}{4}$

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M. Ft. chart. No. x. Sig.: One powder to be taken every two hours.

If there is a loss of appetite the following:—

Ext. gentianæ..... gr. xxx

Syr. aurantii corticis..... ʒv

Aq. destil. q. s. ad..... ʒvi

M. Ft. mistura. Sig.: One tablespoonful before each meal; or:—

Tinct. nucis vom..... m. xxx

Aq. laurocerasi..... ʒiiss

Tinct. quassiae q. s. ad..... ʒi

M. Ft. mistura. Sig.: Fifteen drops to be taken, in water, three times a day.



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For acute cases of gastric catarrh the following is recommended by the author:—

Acidi carbol..... gr.  $\frac{1}{4}$   
Bismuthi subnit..... gr. x  
Mucilaginis acaciæ.....  $\mathfrak{z}$ ss  
Aq. menth. pip. q. s. ad.....  $\mathfrak{z}$ ii

M. Sig.: To be taken in a tablespoonful of water every one two, or three hours.

In acute attacks of gastritis in infants, accompanied by nausea and vomiting, the following is recommended:—

Acidi tartarici..... gr. xv  
Aquæ laurocerasi..... gtt. x-xx  
Aq. destil. q. s. ad.....  $\mathfrak{z}$  v

M. Ft. mistura... Sig.: One dessertspoonful every two hours. If fever is present the following is recommended:—

Acidi hydrochlor. dil..... m. v-x  
Syr. Simplicis.....  $\mathfrak{z}$  ii  
Aq. destil. q. s. ad.....  $\mathfrak{z}$  iii

M. Sig.: One dessertspoonful every two hours, in water. And if gastric irritability has disappeared but fever still remains, the following is suggested:—

Quin. Hydrochloridi..... gr. v.  
Syr. simplicis..... f  $\mathfrak{z}$  iss  
Aq. destil. q. s. ad..... f  $\mathfrak{z}$  iij

M. Sig.: Teaspoonful every two hours.

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Iodine resubl.,..... gr. viij.  
Potass. iodidi,..... ʒviij.  
Syr. sarsap co.,..... ʒ viij.

M. Sig.: ʒ j dose.

As a local application to the chancre:—

Ol. mirbani,..... miv.  
Balsami Peruviani,..... ʒiij.  
Iodoformi,..... ʒ ij.  
Vaselini,..... q. s. ad ʒj.—M.

### FISSURES OF THE NIPPLE.

*Le Progres Medical* quotes from Vinay:—

Liquid vaselin,..... ʒ ss.  
Aristol,..... ʒ j.

M. Apply after the child has nursed.

### PSORIASIS.

R. Acidi salicylici ..... gr. xxx.  
Ungt. picis liq. .... ʒ j.

M. Sig. Rub thoroughly into patch night and morning.

Indications.—Used in chronic cases after scales or crusts have been removed.—*Ex.*

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ROBERTS, M.D. EDITOR AND PROPRIETOR

NASHVILLE, SEPTEMBER, 1904.

No. 9

### *Original Communications.*

#### MEASURES IN DIFFICULT DIGESTION.\*

HARD DOUGLAS, M. D., OF NASHVILLE, TENN.

Each digestion depends upon the correlation of its  
secretion, absorption, and motor efficiency. The  
one disorders the others. Digestion is, therefore,  
as well as a mechanical process.

It is an immemorial custom to think of dyspepsia as a  
failure of gastric secretion. For the slightest ailments, this  
is true; but intractable or recurring difficult digestion  
is a matter of physics than chemistry.

It is a convenient collective term expressive of numer-  
ous ailments which may or may not have their origin in the

the stomach can be recognized only by taking under

of Nashville Academy of Medicine, Tuesday, February 9, 1904.

consideration the history, subjective and objective symptoms. (An office prescription given after the usual formal consultation is not worth, in any instance, the fee charged).

The modern methods employed in the diagnosis of gastric disorders are carried to an unnecessary extreme. Our sin is usually, however, one of omission and not of commission.

If we hope to understand its diseases, we must examine the stomach and its functions after thoroughly eliciting and judicially considering the history and subjective symptoms.

Faults in the chemistry of stomach digestion can be differentiated and intelligently treated only by an analysis of the stomach contents, obtained after some form of test meal. This method tests not only the function of the gastric glands, but the efficiency of the motor power of the stomach.

We are not warranted in assuming any case of difficult digestion to be merely chemical in character until we establish the absence of mechanical features.

Digestive disorders will ever remain the virgin and fertile field for the internist. He should not entertain fear of the surgeon trespassing. Human nature in the future, as in the past, will see to it that the surgeon does not come in until the internist, like Barkis, "is willing."

Two dangers confront us: First, an old one, we persevere too long in the therapeutic means; second, a new one, we resort too early to operative measures. Our salvation lies in accurate diagnosis, absolute honesty, and conservatism.

True conservatism may mean many things; it by no means implies that the surgeon's hand should be withheld.

Disorders of gastric secretion may point to mere chemical disturbance, amenable to medication and diet; or it may be, and often is, the initial symptoms of serious organic lesions.

The time is not ripe for a definite classification of disorders of the stomach into surgical and medical cases. Absolute mechanical conditions do not always require, nor are they necessarily best managed by surgery.

Symptoms referable to the stomach are not always due to gastric disease. Remember that the celiac plexus is the great storm center that gathers breezes from all quarters of the abdo-

men. That you may not think that my mind is bent abnormally in the direction of surgery, I will report a case of gastropptosis in which no surgery was done, yet great relief given.

Mrs. C., aged 35; multipara; suffers constant distress, with a sense of fulness and heaviness of the epigastrium; disagreeable belching, variable appetite, constipation, which is occasionally relieved by diarrhoea; rather scanty, high colored urine; recurring attacks of nausea; copious vomiting, and hemicrania. The vomitus in this case shows delayed stomach digestion; food is sometimes retained in the stomach for eighteen hours. Immediate relief follows copious vomiting. Stomach contents show free hydrochloric acid, apparently not in excess. Physical examination discloses, under inflation and Dehøe's method, displacement downward of the entire stomach, the upper border of the stomach below the seventh costal cartilage. The greater curvature is two inches below the umbilical line. The right border, as well as can be ascertained, is somewhat parallel to the axis of the body. The right kidney slightly movable, uterus normal in position. Inflation of the colon rather negative in its results.

Salol administered upon an empty stomach did not yield the salicyluric test until two hours and fifty minutes. (This shows very slow absorptive power). Diagnosis: Gastropptosis. Treatment: Absolute rest in bed, with elevation of the hips; massage; concentrated nourishment; tincture *nux vomica* before each meal. After three weeks of this treatment, an abdominal bandage was adjusted, and the patient given strict orders as to diet, was permitted to go about her usual duties. Now nine months have elapsed; there has not been a recurrence, and great relief is experienced from the stomach symptoms.

Only this morning a patient presented herself to me. The supposed trouble was retrodisplacement of the uterus, a condition about which there is such an endless furore of nothings. The history of this patient conforms so well to the stereotyped cases of text-books, that I must detail it. She is twenty-eight years old; married two and one-half years. Soon after marriage she had an attack of pelvic pain and soreness, then menstrual disorders followed, and for six months, upon the advice of a physician, her husband refrained from all sexual relations with her. Yet,

notwithstanding this marked consideration, her health did not improve. As a girl she had weighed 130 pounds; gradually she lost flesh. Her stomach complained; constant belching; foul gases were eructated; pyrosis was distressing some hours after eating; she was the constant subject of precordial distress and heart hurry. There was great myasthenia and general prostration. More than half the time was spent in bed.

Naturally a well-poised individual, in spite of great effort at self-control, she became nervous and hysterical. Her urine was scanty, bowels rather inclined to be loose at times. There was no history of colic or severe pain of any kind.

My examination showed a very emaciated, sallow little individual; her weight was eighty-two pounds; her skin was dry and muddy; finger nails brittle and cracked, and hair harsh and fluffy; tongue clean (it may be so with a manure bank behind it); heart and lungs normal; urine analysis negative.

Upon inspection the abdomen was especially flat in the upper zone, rather full below the umbilicus. Under palpation the abdominal aorta was throbbing violently; upper zone of abdomen rather tense, lower zone fuller and more yielding. Right kidney low; the entire organ could be easily palpated; the left had only slightly descended; no change in area of liver dulness; gall bladder region insensitive. Test breakfast not very satisfactory; practically no digestion at end of two hours. Stomach contents only slightly acid. I am quite sure that further test will show subacidity.

Inflation of the stomach with carbonic acid gas and careful percussion, showed a very peculiar stomach. It lay almost vertically. The upper line of tympany was at the costal margin of the eighth rib. From this point it descended as a long, narrow zone of tympany on the left side, reaching to one inch above Pourpart's ligament, then crossing below the umbilicus, curved sharply up to the right. The lesser curvature at the angle was below the umbilicus. The patient was now requested to stand erect, stripped, before us, and while in this position the lowest limits of stomach tympany was marked with flesh pencil.

She now drank a glass of water, and its dulness was noted by percussion, and so on after each glass the rising dulness was



marked. She was able to drink, in all, four glasses of water without discomfort. This brought the dulness an inch above the umbilicus.

This test of Dehoe is very practical and very useful. When the patient assumed the recumbent posture, splashing sounds were elicited all over the displaced stomach.

By manual examination of the uterus and appendages, there was an antiflexed retrodisplaced uterus lying very low in the pelvis. This examination was made at 9 o'clock this morning. At 2 P. M. the above observations were confirmed by Dr. Witt.

It is remarkable to note that this patient does not vomit. She is constantly on the verge of doing so. My diagnosis is: General enteroptosis, gastric particularly, atonic dyspepsia, and the dilatation of atomy. Vomiting will soon become a conspicuous symptom.

The treatment of this case should be both medical and surgical. Prolonged rest in bed, with hips high and head low, at an angle of twenty degrees; only moderate feeding, and at long intervals; lavage of the stomach sufficient to keep it clean; massage; electricity; diet, and try to supply what this woman needs—fat. Her viscera are there, but they have no packing to hold them in place. Later we may take into consideration fixing that kidney, and restoring the uterus to position; but these are unsequential features compared to the gastropptosis with dilatation.

Gastropptosis is a frequent cause of difficult digestion. The salient subjective features are illustrated in the above case. I would emphasize occasional attacks of copious vomiting, vertigo, nervousness and depression, sometimes apprehensions or hallucinations, and quite significant is the symptom of sick headache, undoubtedly of toxic origin.

The objective signs are, first, pulsations of the abdominal aorta: second, splashing sounds: third, corde colique transversi; fourth, displacement of other viscera, viz., colon, kidney, and uterus; fifth, flat epigastrium; sixth, pendulous abdomen.

When distended, the stomach often occupies a somewhat vertical position, its right border being parallel with the axis of the body. The lesser curvature being at, or below, the level of the seventh costal cartilage, i. e., below a line drawn circularly around the body from the tenth dorsal spine. The greater curvature is

below the umbilical line, and in those cases in which the stomach occupies the vertical position, the lowest point may be a little to the right of the umbilicus. This last point is especially noticeable in Mr. A. S. W., a patient who has been seen by a number of members of this Academy, and who, at my request, recently visited Dr. Osler, that gentleman returning him to me with the following quaint statement: "Your patient has gastrop-tosis with dilatation. He is one of those omphalics that circulate around the umbilicus."

Gastrop-tosis is usually associated with enterop-tosis. Malnutrition and general neurasthenia are inevitable results. It is questionable, because of the multiplicity of lesions, if surgery is of special value.

The results of gastroplication are temporary, and probably attributable more to the enforced rest in bed than to the special surgical procedure. Rest in the recumbent position, hips elevated; an occasional lavage; concentrated nitrogenous diet; bitter tonics with antiferments, attention to bowels and general functions, with massage, is the most rational management of these cases.

*Dilatation of the stomach*, so frequently mistaken for gastrop-tosis, may be either an acute or chronic condition.

Acute dilatation of the stomach we have all seen, but not often recognized.

In a recent case of puerperal sepsis, seen with Drs. Altman and Witherspoon, the patient suffered with extreme gastric disturbance and ceaseless regurgitant vomiting. These symptoms developing in the case of puerperal infection may have most naturally been interpreted as general peritonitis. The escape through the stomach tube of volumes of gas and pints of offensive, greenish black fluid, followed by lavage, relieved the distress consequent upon pressure, and, in my judgment, contributed as much to the woman's recovery as the cul de sac incision or the intravenous injection of silver nitrate.

Nine days after a nephrectomy the patient was in good condition, when quite suddenly and inexplicably acute dilatation of the stomach developed, resulting in her death in twelve hours.

With Dr. Barr I saw a case of acute dilatation of the stomach

which came up as a complication of mastoid disease.

Acute dilatation of the stomach was first described by Hilton Fagg. Campbell Thomson has collected some fifty cases, and gives a very thorough exposition of its symptoms.

If amenable at all to surgical operation, it would be through gastro-enterostomy; but as yet no one has had the temerity to try it. If it recurs after thorough evacuation and lavage, it is generally fatal in a few days.

*Atonic Dilatation of the Stomach:* Myasthenia ventriculi occurs frequently as a complication of many digestive disorders, such as hyperchlorhydria, chronic gastric catarrh, atonic dyspepsia, etc. Diagnosis is based upon the discomfort after eating; a sense of fulness and eructations of gas.

Objectively. The splashing sounds; delayed digestion; often the insufficiency of hydrochloric acid; great fermentation. When the stomach is inflated, or Dehøe's method employed, its greater curvature will be found to descend below the umbilical line. Peristaltic waves not visible. Clinically speaking, both acute and atonic dilatation are of minor importance as compared to consecutive ectasia, the consequence of pyloric obstruction.

Mechanical obstruction of the pylorus or duodenum, giving rise to dilatation of the stomach, with ischyochymia, is so frequent that scarcely a week passes that we do not meet with it.

Congenital narrowing of the pylorus is now a recognized ailment of childhood, though it may not become marked for some years.

I have now under observation two little girls in both of whom I have been able to demonstrate pyloric obstruction with dilatation.

Simple hyperchlorhydria may, by its irritating effect, give rise to pylorospasm, with consequent dilatation. It is probable, however, in such cases there is an ulcer near the pylorus.

Organic stricture of the pylorus may be innocent or malignant. Cicatricial contraction following healed ulceration is the most common of all causes, and, fortunately, the one most easily remedied.

Carcinoma of the pylorus is a well recognized cause of dilatation. The pylorus may be compressed by tumors of other than

gastric origin. Adhesions from paragastritis by traction and constriction occlude the pyloric opening, and lead to the delayed passage of food and dilatation.

In this connection I may mention two cases of gall stone in which the adhesions, the omentum and colon, so compressed the first portion of the duodenum as to interfere with the lumen of the gut, and gave rise to consecutive ectasia gastrica.

In dilatation of the stomach digestion is made difficult because of the loss of motor power, increase of secretion, and the arrest of absorption. So in this condition we have typified both mechanical and chemical indigestion.

Discomfort, a sense of fulness and weight, vomiting of partially digested contents at variable intervals, are the important subjective symptoms. The loss of weight, the anæmia, scanty urine, constipation, general physical debility, mental lethargy, are less significant symptoms. The diagnosis of the condition is easily achieved if we employ modern methods.

By palpation alone the outlines of the stomach may be detected. It is well to remember that the normal stomach is tucked away under the left arch of the diaphragm, and is not palpable when empty.

In suspected dilatation, if the patient will fast for twelve hours, and then be given a test breakfast of Ewald, remnants of the roll will be withdrawn; or if the test meal of Loubie be employed, partially digested food will remain in the stomach more than seven hours. If we distend the stomach with carbonic acid gas, it lies athwart the upper zone of the abdomen like a big air cushion. Its exact position depends upon what was the normal position of the stomach, which, we well know, is quite variable.

To declare that a stomach is dilated, we must be able to outline by percussion and auscultory percussion, both curvatures of the stomach. The greater curvature must be below the umbilical line, and the lesser curvature above the left seventh costal cartilage. It may reach to the fourth, and the greater curvature to Poupart's ligament.

That a dilated stomach may contain as much as seventeen pounds of fluid, gives us some idea of its enormous capacity. Percussion of the inflated stomach is the most reliable means of

detecting dilatation, but others should be employed.

If the patient is allowed to fast for some hours, and then stand before us stripped, with the stomach empty, we may note the lower limit of stomach tympany. Now permit him to drink water, a glassful at a time, and after each glass percussion will note the rising dulness.

Leube and Boas attach much consequence to our ability to palpate, in thin subjects, the stomach tube through the abdominal wall. Einhorn's gastrodiaPHONE, with its transillumination, is a troublesome and unnecessary instrument. By inspection alone the diagnosis was made by Osler in ten out of thirteen cases.

Remember that in obstructive dilatation there is muscular hypertrophy, and upon inspection we not only note asymmetry of the abdomen, but visible waves of peristalsis rise in distinct patterns across the violently working stomach. The contents of a dilated stomach depends largely upon the character of the obstruction. As a rule, if the cause is malignant, there is an absence of hydrochloric acid, and an excess of lactic. If due to a cicatrized ulcer, free hydrochloric acid in abundance is usually found, unless the patient has been the subject of adenia, i. e., exhausted gland secretion.

In obstruction due to gall-stone or paragastric adhesions, as also in pylorospasm, hydrochloric acid is in abundance.

When confronted with a case of dilatation of the stomach, the indicated procedure depends, in some measure, upon the cause. If the condition is one of malignancy, and all the disease can be removed, pylorotomy with gastrojejunostomy, is a better procedure than pylorotomy, followed by gastro-duodenostomy. In advanced malignancy we are justified in doing a gastro-enterostomy for temporary relief.

Obstruction from perigastric adhesion is sometimes relieved by releasing the adhesions, but in these cases, if dilatation is a marked feature, an anastomosis should be made. Narrowing of the pylorus from innocent causes is sometimes treated by pyloroplasty — a simple procedure with low mortality, but not as permanently beneficial as gastro-enterostomy.

*Ulcer:* 75% of all cases of difficult digestion requiring surgery for its relief, are due to ulcer and its complication. There are

some erroneous ideas ingrafted into the minds of the profession which should be eradicated. It is now known that ulcer is not infrequently met with in children. It is also shown by more recent statistics that it is practically as common in males as in females.

We must further recognize that it may be present in individuals apparently in perfect health.

It is a well grounded belief that ulcers will heal under rest and diet. This is undeniably true in many instances, yet are we alive to the possibilities of a fatal hemorrhage or sudden perforation while waiting, and do we recognize that the very process by which they heal, viz: that of cicatrization, may in itself become the cause of obstruction and dilatation and that in 6% of such cicatrices, carcinoma develops?

These are great, and in some instances, remote dangers that call for the surgical treatment of gastric ulcer.

To this audience it is unnecessary to recount in detail, that distressing train of symptoms by which we recognize gastric ulceration. In passing, I would refer only briefly to the distress upon taking food; the time at which it occurs is in some measure diagnostic of the seat of ulceration.

We should bear in mind that vomiting is not always present in ulceration. It is a conspicuous symptom, however, when ulcer is situated near the pylorus; then the cicatrization or pylorospasm produces occlusion of this opening and we have the vomiting of retention.

The pain in ulcer is variable; tenderness, however, is more diagnostic. It may be directly over the seat of ulceration, which is usually in the left epigastric triangle.

Quite significant is Boas' tender spot, just to the left of the tenth to the twelfth dorsal vertebra.

Hyperacidity is so constantly associated with gastric and duodenal ulceration both as a cause and an effect, that we now consider hyperchlorhydria in the group of diagnostic symptoms.

We are prone to look upon gastric ulceration as comparatively harmless. A few catastrophies such as I have seen, may change one's views. I have seen four deaths from hemorrhage due to gastric ulceration. Three of these patients had a history of

difficult digestion and phenomena of peptic ulcer. In one, all symptoms were latent, and, without warning, a fearful hemorrhage came on that resulted in death in a few hours.

Such fatalities are infrequent. Medical means alone, will suffice in almost every instance in controlling the hemorrhage.

It is scarcely necessary, indeed not advisable, according to our latest teaching, to seek for the bleeding ulcer. However, this point admits of discussion.

Disastrous hemorrhage is only likely to occur in the acute ulcer. It is the chronic ulcer that may exist symptomlessly, or in other instances, be attended with all those phenomena that make life intolerable, in which there is the ever-present danger of perforation—a catastrophe almost inevitably fatal.

It cannot be denied that a slowly perforating ulcer may acquire adhesions that will segregate the escaping stomach contents or may, indeed, prevent their escape.

But why trust to the unusual? It is quite the rule that when an ulcer perforates the wall of the stomach for a fistulous communication to be established between the stomach and the greater or lesser peritoneal cavity, and death is the almost inevitable sequence.

Undoubtedly perforating gastric ulcer is a rare condition with us, but many cases have doubtless occurred and escaped detection. I feel quite sure that some of my cases diagnosed as appendicitis with general peritonitis, operated upon some years back, when I did less thorough surgery than I do to-day, were cases of peritonitis due to gastric perforation and not to appendicitis.

In forty-nine cases of gastric perforation reported by Moynihan, eighteen were diagnosed as appendicitis.

The escaping contents are directed by the promontory of the transverse colon to the right iliac fossa, and this region becomes the seat of symptoms.

A point that I would emphasize is that many patients are declared to be the subjects of malignant disease of the stomach upon the evidence of a palpable tumor and distressing gastric symptoms.

There is something different between the feel of an inflammatory mass, with its smooth resiliency, and the gritty, hard, nodular



sensation of a neoplasm; and in all cases of doubt, our patients should have the benefit of an exploratory operation.

When an acute ulcer bleeds profusely, or a chronic ulcer slightly and intermittently, or when gastric symptoms, subjective and objective, denote the presence of ulceration, surely nature is speaking to us in plain and ominous language. If we realize the dangers, present and remote; if we have pity in our heart for the suffering mortal, knowing that certain relief can be obtained through gastro-enterostomy, and that this operation is not attended by more than three or four per cent. of mortality, even less in some hands; are we not violating the rules of science and holding in contempt the blessing of skill and knowledge that the Almighty has given us, when we refuse, or hesitate to deliver our patients from chronic invalidism or death by the simple procedure of gastro-enterostomy?

Experience has demonstrated that it is unnecessary to cauterize, constrict, or ligate the bleeding ulcer; that it is unnecessary to excise the cicatrizing chronic ulcer. Hemorrhage will be controlled and ulceration will heal if the stomach wall is placed at rest by the establishment of a passive opening.

*Carcinoma of the Stomach:* If the remarks of John B. Murphy before the Philadelphia Academy of Medicine published in the December number of the *Annals of Surgery* were in the hands of every general practitioner of medicine, there would be no occasion for further discussion of this subject.

Forty-five per cent. of all cases of carcinoma affect the stomach, and it is estimated that as high as three and one-half per cent. of all deaths are due to carcinoma. These figures at once impress us with the horrible frequency of this disease.

Within the past year I have seen four undoubted cases of cancer of the stomach. One has just passed from under my observation. A brief notice of his case will serve to emphasize the symptomatology.

Several of my colleagues, some of whom are present here tonight, saw this case with me. An Englishman fifty-seven years of age, robust physique, when in health weighing one hundred and ninety pounds; was perfectly well until seven months ago. His first distress was difficult digestion, expressed in slight epi-



gastric pain, a sense of fulness and weight in the abdomen; frequent belching, precordial distress, some pyrosis, occasional vomiting, and very obstinate constipation. These symptoms continued for something more than five months without any appreciable deterioration in his general health. Eight weeks before consulting me, vomiting became a conspicuous symptom. It had the following significant characteristics: it would occur at intervals varying from one to three days, and invariably the matter ejected was out of all proportion to the amount taken, and the vomitus contained particles of food that had been retained in the stomach many hours and sometimes days. Before vomiting, he would be in great distress, through distention and fullness. His trousers were always too tight. His abdomen was enlarged; he would suffer from vertigo, was drowsy and dull. Backache and sciatica annoyed him. After disgorging freely, there was great sense of relief and comparative comfort, save a gnawing pain midway between the umbilicus and ensiform.

About this time, *i. e.* five months from his initial symptom, a tumor developed. At my examination a few weeks since, this tumor was as large as an orange, slightly movable, separate from the liver, occupied a central position and extended to the left. Dull upon light percussion, hard and irregular to the feel.

A test breakfast was given. The chemical analysis of the stomach contents showed an absence of hydrochloric acid and an abundance of lactic, together with bacterial fermentation. Some blood was found microscopically.

Inflation of the stomach showed the organ dilated, its greater curvature below the umbilicus; the lesser, high in the thorax. Peristaltic waves were everywhere visible; and a significant point, the tumor became more resonant under distention.

The general condition of the patient did not warrant me in offering encouragement. I merely advised gastro-enterostomy for temporary relief; this was declined. A recent letter tells that his death is close at hand. This is the roughly-drawn picture of neglected carcimona of the stomach.

Does surgery offer anything to these cases? "There are some thirteen cases," quoting Murphy, "of complete gastrectomies. Several have lived from six to eleven months. Delatour's

(Brooklyn) patient lived seventeen months. So much for the grand procedure.

"If," says Mikulicz, "we do not prolong life but a single day, the operation is still justified."

A less serious procedure is that of pylorotomy, that has a mortality in the hands of Kocher, of 8.78% only. The average surgeon may expect a mortality of about forty per cent.

There are some of us who believe in cancer of the stomach as in some other organs—an absolute and permanent cure is quite an exceptional result; yet, no one can deny that life is prolonged; suffering is mitigated; health and vigor restored sometimes for years, sometimes only for months, by some safe and often simple procedure.

Therefore, gentlemen, I implore you not to permit your patients with carcinoma of the stomach to die without appealing to surgery. Make your diagnosis by painstaking examination, while the case is only one of difficult digestion. Seek the disease before it has passed to the lymphatic glands, and when confined to a limited area. Complete ablation may be done with the hope and confidence of permanent relief.

If this procedure, in the face of developments, seems unwise, a gastro-enterotomy, preferably after the manner of Moynihan, will, as a relieving measure, justify the hazard.

I have only opened the subject of difficult digestion from causes that are in the main amenable to surgical relief. The scope of this topic begins with dental caries and ends with piles. There are many conditions, especially movable kidney, renal calculus, gall-stone, and appendicitis that give rise to difficult digestion early in their development.

Surgery is successful in direct ratio to its timeliness; and the lesson that we all have to learn is a thorough examination of our patients regardless of the apparent insignificance of symptoms.

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IN SURGERY it is always important to beware of oft-repeated efforts. Never try too often to catheterize a distended bladder if you don't succeed soon. It is better to tap. Never try too long to reduce a strangulated hernia. It is better to cut. Never try too often to intubate a child; if you are not very familiar with the operation it is better to tracheotomize.—*Ex.*

## AORTIC REGURGITATION.\*

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BY W. H. WITT, M. D., OF NASHVILLE, TENN.

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Disease of the aortic valves has certain features that so clearly distinguish it from mitral disease that I think the conditions arising here may very properly have independent consideration. The physical changes resulting from disease are a stenosis of the aortic valves or their incompetence to close the orifice. Pure stenosis of the aortic valves is rather rare according to such authorities as Broadbent and Osler. For lack of time I shall not consider aortic stenosis, nor regurgitation due to sudden mechanical injury to a cusp, allowing leakage. I shall only take up aortic regurgitation, discussing chiefly the pathology and prognosis. The essential features of aortic regurgitation are as follows: There is a leakage of blood during diastole from the recoiling arterial system into the left ventricle. The regurgitated blood comes into a relaxed chamber and meets there the normal current of blood from the left auricle. These streams overflow a ventricle whose walls are not on guard and gradually dilate it. With dilatation comes hypertrophy, which may be well or poorly sustained, according to conditions to be mentioned later. The heart becomes enlarged — sometimes enormously so; the enlargement being chiefly downward and to the left. The apex beat may be seen and felt in the sixth or even seventh intercostal space. Later, from degenerative changes, violent strain or other cause, the chamber dilates with great rapidity and is no longer able to force the blood properly into the arteries. If rather sudden death does not occur at this stage there will be overstretching of the mitral valve, engorgement and enlargement of right heart with the usual train of mitral symptoms.

On inspection we usually find a heaving impulse with misplaced apex beat. The prominent arteries pulsate visibly and the brachials, if very sclerotic, may be thrown into curves. Capillary and even venous pulse may be observed. In advanced cases with weak heart none of these signs may be present. On palpation of the arteries we usually get the Corrigan or collapsing pulse,

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\* Read at Regular Meeting of the Nashville Academy of Medicine.

and the radial pulse is often delayed. On auscultation we get a diastolic murmur of varying degrees of roughness and loudness, and with varying points of greatest intensity and lines of transmission. Usually we get it best in the right second space — transmitted upward to right sterno-clavicular joint and down the right of sternum to say the fourth space. Not uncommonly it is heard best to the left of the sternum in a similar area. It is often heard in the apex area and in a few cases is heard there as a presystolic murmur, the so-called Flint murmur. The murmur of aortic regurgitation replaces more or less completely the second sound.

Among the symptoms that the patient complains of, we find, in addition to the common symptoms of shortness of breath, cough, etc., distinct attacks of faintness and dizziness, especially on rising. Cardiac pain is much more common with aortic disease than with mitral and varies from slight and transient distress to genuine anguish. Distressing dreams and disturbed sleep, even in cases not apparently serious, are very common and are important phenomena. These symptoms grow no doubt out of the poorly nourished condition of the brain, which is more marked in disease of the aortic valves than in mitral disease of apparently similar severity. Mental aberration is not at all unusual in the advanced cases.

Aortic regurgitation is, in itself, a purely mechanical condition, and one in the great majority of cases easily diagnosed. I shall not go into the question of differential diagnosis, between the murmur of aortic regurgitation and the other murmurs with which it might be confounded. I shall take for granted that a diagnosis of leakage is made. But the mere recognition of the fact that there is a reflux of blood from the aorta into the left ventricle is only a small part of a diagnosis in the true sense of the word. A diagnosis that is of any great value to patient or doctor is a broad one and involves answers to the following questions:—

(1) The cause of the valvular disease. Does it grow out of rheumatic endocarditis, or is it a result of sclerotic changes incident to old age, vicious habits, family history, and syphilis?

(2) Is the leakage large or small?

(3) Is the consequent hypertrophy compensatory or has compensation failed?

(4) If the symptoms point to loss of compensation, have they just occurred; under what circumstances did they first occur? Is it in a young person, or one past middle age?

(5) What is the nutritional state of the heart muscle?

(6) What is the condition of the arteries?

(7) Is there coincident leakage of the mitral valves?

The answer to these questions cannot be made until, as far as possible, there has been a careful physical examination of the heart and blood vessels, and other viscera, as well as a history of the case, including the subjective symptoms. Each question is vital and though they overlap each other to some extent I shall notice them in order and hope to show their importance in reaching a diagnosis, or what is more to the point, a prognosis. After all it is the prognosis, not diagnosis, that a cardiopath wishes. When he is told he has heart disease, he has a right to expect from his physician an intelligent opinion as to just what that term implies, for we all well know that it may mean everything or nothing.

1() The cause of the valvular disease.

There are two great causes of structural changes in the aortic valves. One is endocarditis, the other degenerative changes by which the cusps are warped and curled on the edge until they no longer cöapt nicely. Endocarditis is usually associated with rheumatism, and, as we know, shows a preference for the mitral over the aortic valves. However, in a good per cent. of cases of endocarditis the latter are attacked. I am quite sure the profession at large is inclined to underrate the frequency with which rheumatism attacks the aortic valves. A large per cent. of cases of aortic incompetence and nearly all genuine cases of aortic stenosis have this origin. The formation of vegetations large or small on the leaflets is quite competent to so distort them as to permit leakage. But the pathology present in these endocarditic cases is essentially a stationary one, and, barring fresh attacks of inflammation with the formation of new vegetations, the distortion of valves and the amount of leakage remain about the same. An exception to this would be acute endocarditis

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after middle age — the period of sclerotic tendencies. But acute endocarditis is rather rare after middle life, being very much more prone to attack children and young adults. A definite history, then, of rheumatic fever, especially if the patient be under forty, is of great importance in the broader diagnosis of which I speak; and that, too, whether or not endocarditis has been made out at the time of the joint involvement. We know as a matter of fact that it is quite difficult to be sure of an endocarditis in a severe attack of rheumatism, even if a murmur is heard.

Valvular disease of endocarditic origin, particularly if between the ages of ten and forty, belongs to a heart capable of taking on the necessary compensatory hypertrophy; there being no hindrance to its getting its full supply of nutrition. It is very different in young children and old people. Broadbent goes so far as to say that all really satisfactory cases of compensation have been those that were under twenty when the valves were first attacked. In these it may be perfect and permanent, especially if there is a good family history. Given then, an aortic regurgitant murmur in a young person, with a history of rheumatism, and without symptoms of loss of compensation, we are justified in saying the patient's pathology is practically limited to his aortic valves and left ventricle. His ventricle is dilated, but proportionately hypertrophied; the heart muscle is firm and its nutrition good. He may, and possibly will, live many years, even to his three score and ten. Of course, if compensation has failed, with or without mitral leakage, the prognosis is very different. When compensation fails in these young patients, they become for all practical purposes cases of mitral regurgitation, with gradual involvement of the right heart, increasing dropsy, and a slow death, a sudden death being rare.

The etiology of aortic disease occurring after middle life is altogether different from that we have discussed. Briefly, a sclerotic degenerative process attacks the valves; they curl and twist and leakage results, and this is but a part of a general fibrosis taking place throughout the arterial system and to a less extent, in certain viscera. And while the resulting regurgitation of blood into the ventricles may be the most *prominent* feature of the case, it is not by any means always the most important.

Age, a family tendency to retrograde change, hard work, alcoholism, nephritis, gout, and syphilis are the chief conditions leading to this pathology. Age, with any one of the others, is quite enough. It is not contended that these changes never occur in patients under forty, but the great majority occur in those past that age. Not only are the fibrotic changes, of which the aortic incompetence is a result, general in their distribution, but they are progressive in their pathology. Dominated by this progressive pathology the distorted valves are not stationary, but the leakage is apt to get larger and larger. This greater reflex, coupled with an ever-increasing resistance to the peripheral circulation, puts a rapidly growing strain on the left ventricle.

And then, the ventricular walls themselves are in no condition to assume this larger work. Whether we believe that the coronary arteries are filled during systole or diastole, it seems to be true that marked regurgitation interferes very much with the flow of blood into these channels. Moreover, the coronaries themselves partake of the general pathology; their walls are diseased, their calibre lessened and the proper amount of blood cannot reach the heart wall for nutritive purposes. Degeneration of the ventricular muscle is a necessary consequence, and a chamber whose work is increasing from day to day becomes less and less able to do what is required. Hypertrophy is slow, dilatation fast, and heart failure is at hand. The dilatation and failure may be very slow, or very rapid and suddenly fatal.

Sudden death is more common in aortic regurgitation than in any other form of heart disease. The exact cause is hard to find and no doubt varies much. Sudden anæmia of brain, called fatal syncope, is often assigned as the cause. Sudden coronary thrombosis, acute dilatation of heart, and cardiac ischemia are all no doubt present in some cases.

(2) Is the leakage large or small?

In an analysis of a case seen for the first time, one will naturally try to form some idea as to the amount of the leakage. Close attention to several signs will enable us to form a fairly definite opinion on this point. (a) It is well to bear in mind that the character of the murmur may help us a little. Generally speaking, a loud, shrill murmur indicates a small leakage, and a



low-pitched, short murmur a wide open orifice. But we must not put too much store by this. (b) The character of the pulse is often of great help. We are accustomed to associate the Corrigan pulse with regurgitation. If the regurgitation is small, this collapsing feature of the pulse is not marked. The greater the collapse the greater the leakage. However, this is not universal. Broadbent says we must not forget that the following conditions make overfilling and sudden collapse impossible: 1. A coincident aortic stenosis. 2. A ventricular wall so degenerated that a powerful systole is impossible. 3. Incompetence associated with stiff arteries or aortic dilatation. Any of these conditions would prevent the overfilling and sudden collapse, upon which the Corrigan pulse depends for its typical exhibition.

According to Broadbent the most important guide to the extent of the lesion is the presence or absence of the aortic second sound. I shall quote his words: "We must listen for this not at the apex nor in the aortic cone, but in the neck. A second sound of some kind, probably the pulmonic conducted, is often heard at the apex or the base, but it has not the same significance. The point of the sign is this: The aortic second sound is produced by the sudden tension of the aorta and its semilunar valves at the moment of closure: it is not their clicking as they meet, or the tension of the valves alone under the column of blood, but the vibration of the entire ascending aorta. If then the incompetence be considerable, there cannot be the sudden check to the column of blood which sets the aorta vibrating, and the diastolic murmur takes the place of the second sound. If, on the contrary, the leakage is small, the required check or shock is given by the closing valves, and the second sound is distinct although there may be a murmur. It is not the murmur, which may be loud or feeble, that drowns the second sound. On listening in the neck over the carotid artery, we have the advantage of being out of reach both of the diastolic murmur and the pulmonic second, and the tension in the aorta must be real in order that the second sound may be heard there. A second sound therefore, heard in the neck, indicates that the regurgitation is small in amount and is consequently a favorable prognostic element."

3. Has hypertrophy kept pace with dilatation?



This is always a vital question and can commonly be easily determined. A heart whose necessary dilatation is fully compensated gives rise to no symptoms, or if so, they occur only on exertion and are transient. When compensation fails, we have more or less marked degree, the usual train of symptoms, shortness of breath and irregular pulse with distinct attacks of vertigo and cardiac pain. It sometimes happens that in the course of a routine examination — as for life insurance — a doctor detects an aortic regurgitation in a patient who seems in perfect health and has had no symptom of heart disease. I saw a case of this kind recently. In the presence of such a finding, it is the doctor's duty to give the patient the prognosis, which can only be done after a careful analysis of the etiology and a full understanding of the patient's habits and family history. In deciding whether compensation is perfect in disease at the aortic valve, one must not put too much stress on edema and shortness of breath. Edema is not at all a prominent feature of aortic disease and its absence would mean nothing. "Shortness of breath" is a term that laymen may not fully understand. If the patient tires easily on any extra exertion, and has a sense of distress about the pericardium and has attacks of vertigo — facts which may not be brought out unless specific questions are asked — the chances are that compensation is failing.

#### 4. Compensation having failed what does it signify?

In answering this question, the age of the patient deserves special consideration. Children under ten years bear heart lesions badly. At this time of life the heart seems unable to satisfactorily take on hypertrophy, so that upon the appearance of signs of even slight loss of compensation we are forced to make a rather gloomy prognosis. After middle life, for reasons that have been given, the onset of symptoms has again a serious bearing: from fifteen to forty years we are able by appropriate treatment to do much more for the patient. The station in life is always to be considered in the prognosis — this term is meant to include the character of work done by the patient. If he is able to take advantage of the slightest warning afforded by the first signs of failure and is willing to do so, the prognosis becomes more favorable. On the other hand, if poverty or other circum-

stance forces him to continue hard work and constant exposure, a gloomy prognosis is made. The habits of the patient are of importance. In alcoholics, high livers generally, and in a class of people constantly on a nervous strain, a less favorable outlook is promised than in those of sober and quiet mode of life. The exact circumstance under which the symptoms of failure were first developed are important. A laboring man developing shortness of breath and cardiac distress after an ordinary day's work, is in worse state than a patient who probably notices distress after running for a car. The severity of the first attack has an interest. If it is slight and transient it may mean very little; if it is severe, and return to normal is slow, it is of very serious import. If attacks return on slight exertion, it is clear that irreparable damage has been done. It happens sometimes that an unusually severe exertion produces at the time no symptoms, yet the subsequent exertion not unusual in intensity, promptly brings on cardiac distress. Babcock details such a case.

When the patient finally reaches that stage in which the slightest exertion, or such a circumstance as a full stomach or constipation is sure to bring on an attack, the outlook becomes very gloomy and life is not apt to be much prolonged.

5. What is the nutritional state of the heart muscle?

An organ called on to do extra work should have its nutriment furnished without any hindrance. In aortic regurgitation of the rheumatic type, the blood supply will be good unless the regurgitation is so great as to suddenly reduce the blood pressure to almost nil. This sudden arterial collapse will especially affect the supply to the coronaries; they being filled, according to general belief, chiefly during diastole. In the other type of cases, however, the coronary arteries taking part in the general vascular degeneration, the nutrition of the heart begins to suffer early. A proper estimate of the nutrition of the heart may be difficult to determine, but we can usually come fairly near the truth. I mean by this that myocardial degeneration can usually be made out with a fair degree of certainty. Our diagnosis of such a condition is made partly from the detection of associate pathology and partly by a group of symptoms, fairly definite, that are commonly associated with that condition. Age and arterio-sclerosis,

especially if associated with alcohol and syphilis, suggest myocardial change. The symptoms referable to the heart itself that help us to be more definite in our diagnosis are: (1) Irregularity in the pulse beats, and by irregularity I refer not only to lack of rhythm, but especially variation in *force* of the beats. "The nervous heart" is a phase we often see, and with a certain type of neurotics it is entirely proper; but when a pulse unrhythmic in time, unequal in the force of successive beats in a person past forty-five, the word "nervous" ought not to be applied to it unless other causes have been eliminated. At the menopause we find various vascular symptoms and some cardiac, but it is possible even at this period to make a fairly accurate diagnosis.

(2) Next to irregularity of pulse are certain symptoms of cardiac distress varying from slight precordial uneasiness to genuine attacks of angina. In advanced cases these may be brought on by very slight exertion or some indiscretion in eating. It is no means easy to determine the cause of all these symptoms. Perhaps sudden ischemia of the heart so likely to occur on exertion where there is regurgitation, coronary disease, or sudden strain put on left ventricle by the raised blood pressure that attends general muscular exertion, are the chief causes of the phenomena. It is in these cases of aortic disease, too, that we see such distressing disturbance of sleep—and that, too, in patients who do not present many symptoms ordinarily referred to the heart.

#### 6. What is the condition of the arteries?

Marked atheroma with aortic regurgitation, particularly of recent origin, makes a bad prognosis. The principal feature of the arterial system is the state of coronary vessels. This has been sufficiently referred to under the nutrition of the heart. A case of aortic regurgitation without arterio-sclerosis gives a better prognosis.

#### 7. Is there leakage of mitral valves?

It has been a mooted question whether the incidence of relative insufficiency of mitral valves may act favorably in a case of aortic regurgitation. Babcock takes the position that the distress in many cases is actually relieved by this development, holding that there is less tension on the disabled ventricle. He quotes other

in support of his contention. Broadbent, on the other hand, antagonizes this position. Whatever may occur in an individual case, in the majority leakage at mitral must be considered a bad sign. It can only come with great dilatation and muscular weakness about mitral orifice. Following it in rapid sequence are apt to come pulmonary congestion, overworked right heart, tricuspid reflux, and general venous stasis.

Such an analysis as I have hinted at in the answer to these various questions will be of great help in giving a prognosis in these heart cases. We may often be deceived and reach a wrong conclusion as to the severity of the case, but in most cases our efforts will be properly rewarded.

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## *Records, Recollections and Reminiscences.*

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### ANNUAL MEETING OF THE ASSOCIATION OF MEDICAL OFFICERS OF THE ARMY AND NAVY OF THE CONFEDERACY.

*(Continued from August Number.)*

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WEDNESDAY, JUNE 15, 1904.

Meeting called to order at 9 o'clock by President, Dr. J. R. Gildersleeve.

Dr. Cain asked if there were any constitution and by-laws of the Association. Dr. Plunket, Secretary *pro tem*, then read from printed pamphlet the constitution and by-laws of the Association. This led to a discussion as to applicants for membership as follows:—

Dr. Alfred Jones: Mr. Chairman, do I understand that a committee must investigate the right and title of those who apply for membership? It seems to me that there ought to be some one to pass on the credentials of those who are seeking to become members.

Dr. J. B. Cowan: The Executive Committee will pass upon that. That is all that is necessary.

The President moved that the Secretary furnish a list of all present, and additions to the Association, and a list of applications for membership. Seconded and carried.

Dr. J. D. Plunket, Acting Secretary, announced that he had been requested to say that at 11 o'clock in the room above a clinic (abdominal section) would be held by Dr. W. D. Haggard of Nashville, to which all members were invited. Dr. Haggard then spoke a few words of welcome in behalf of the Medical Department of the University of Tennessee.

All members of the Association present were requested to come forward and pay their dues and give their names in full that a record might be obtained of those present.

The following paper was then read by Dr. J. P. Moore, of Yazoo City, Miss., on

#### GUN-SHOT WOUND OF THE HEAD.

I scarcely know how to begin a paper in relation to the civil war, however insignificant, without some prelude to the heroism, self sacrifice, hardships, and privations of our heroic army in all its branches, and especially in its medical and surgical department, no less than in the fighting line. The difficulties under which we accomplished so much has attracted the admiration of the civilized world. Poorly equipped with appliances, holding at bay for four years a foe three times our number as magnificently equipped as the world could supply, meeting them on a thousand battlefields, killing and wounding as many as our entire enlisted army. The Confederate surgeon was in like manner handicapped for the treatment and care of the sick and wounded. Short of medicines of the most urgent need, proper diet not to be had, clothing and shelter scant and scarce, under most unfavorable and unpromising circumstances, without stimulants, compelled to extemporize as best we could; while the Federal surgeon had at his command everything the wide world could bestow, and yet statistics give us the verdict of being the most successful in the management of the sick and wounded. But notwithstanding this, we failed, we lost the cause, and where is our Confederation? It is in the exalted character of our Southern people, showing themselves as heroic and brave under

disaster and reverses as in the flush of victory, keeping the plighted faith of their great commander, R. E. Lee, at Appomatox, returning home building up their ruined, wasted, and desolate estates; and adjusting themselves to citizenship under the Stars and Stripes.

So then, our Confederation is in the pride of the knowledge that we are surely the equal, man to man, of our Northern brothers, as testified in battles, in surgery and medicine, in statesmanship, in law, on the hustings, in politics; in a word, in all the vocations of life.

Personally I began duty as a surgeon of the Confederate States early in the year 1863, twelve miles from Vicksburg, in hospital at Milldale Church. On the investment of Vicksburg I fell into the hands of the Federals, by whom I was treated with great courtesy and politeness, given open order to draw for anything wanted for sick or myself, paroling all convalescents as soon as able to travel home. The hospital emptied, I was given a pass to my home, where I remained until the reorganization of Gen. Pemberton's army at Meridian, Miss. At this time and place I was assigned to duty as surgeon of the Tenth Tennessee Regiment, every man in it an Irishman except the adjutant. At once the army was ordered to North Georgia to support Gen. Bragg, who was being close pressed. We arrived just in time to engage in the great battle of Chickamauga. My regiment went in with 157 muskets, and came out with 57; one hundred killed and wounded. This great battle closed about dark Sunday, Sept. 20, 1863. Monday, late in the afternoon, after all my wounded had been cared for and made as comfortable as possible, I rode over to a field hospital some half a mile distant. There I found an acquaintance, a friend, semi-conscious, and totally neglected. I could not find the surgeon. He was shot from front to back centrally through the frontal bone, cutting deep enough to sever the brain membranes and a slight depth of brain tissue. A large protrusion of brain substance lying out on his head, an enormous cerebral hernia, in amount that would surely approximate an ounce. His hair was a mat of hard dried blood, his clothes stiff with blood; a most pitiful, forlorn-looking object. I knew the man well. He was a high-toned gentleman, a newspaper editor,

a very terse, strong writer. I got some soldiers to put him on my horse and hold him there and thus carried him to my camp, where I thoroughly cleaned his head, scraped off the protruding brain matter, dressed the wound, put compress and bandage on, put clean clothes on him, and sent him to the hospital.

He made a perfect recovery without the slightest loss of mental vigor or muscular power. He moved to Yazoo City after the war, established his newspaper there and died about twenty years after the war of a disease having no connection with his injury. This man was Col. J. L. McCullum, whom doubtless some one here knows.

A similar case to this was in the person of a young man named Dibon, wounded in precisely a similar manner in the campaign from Dalton to Atlanta. The loss of brain substance was considerable, though not as much as in the former case. The young man lived in Columbus, Ga. I don't know the result, as his brother carried him home. I never heard of him again, although he was doing well, conscious and intelligent when he passed from under my observation.

Dr. J. B. Cowan: Where did the brain matter ooze out?

Dr. J. F. Moore: Near the center of the top part of the head.

Dr. J. B. Cowan: I have known many cases of injury to the head to recover. In regard to injuries of this kind, we were not prepared for that kind of work in the army. If to-day we had to treat them as we did then, they would die, unless we have a trained nurse. Gentlemen, why was it that our men recovered, recovered under most serious circumstances, when to-day if you leave the least sanitary precaution undone, there is danger of bad results? Why was it that we had such success then? We did have success, and wonderful success, as you will see if you examine the records. We have it on file and we know it is true. Why was it? I think I can give you the solution of it. I had the opportunity of telling my Northern friends the reason, and when I did, it was in the presence of a number of Federal surgeons. I will tell you the reason. When the tocsin of war sounded in the South, the best men in the medical profession were the first to take up arms and go into the army, and our men who had come from New York and Philadelphia, nearly all had



taken hospital courses, and all had the best opportunities in the best schools in the country, and were best fitted for work at that time. The best men in the South were the ones who went into the army. Not so in the Federal army.

Gentlemen, I have been with them where they had an army of ten thousand men, and they had over sixty cases demanding operation and yet no surgeon present. I put my young assistants to work on them. Here is your chance, I said. I helped them all I could, and we did thirty-eight capital operations for them. Nearly ten thousand, and they had not a single practicing surgeon, or one that could do the work. After the battle of Perryville, I moved up to Danville. There they did a great many operations with the surgeons in charge.

Now, gentlemen, the difference was this. The flower of the medical profession in the South were the surgeons in the army, while the Northern army had men with them who had some reputation and some ability, and they had good places there, and if they did not get there, the patient was waited on by incompetent men. Sixty per cent. of the field work and thirty-four and one-half per cent. of the hospital work was done by surgeons in the Southern army.

Dr. J. S. Cain, Nashville: The case reported by Dr. Moore is one of those extraordinary recoveries which we met with in the army frequently. You evidently did not expect that man to get well. Nobody could expect it. I saw a great many just such cases that we cannot account for. We would not expect a man hurt that way to recover now. If he had been a doctor or a preacher, it would have been fatal, but being an editor or a lawyer, it would not hurt him. It made no difference, so he got well.

Dr. Cowan has broached a subject that I have thought of a great deal, our remarkable success as surgeons in the army under peculiar circumstances. Our successes were remarkable. Dr. Cowan answers it in a great measure when he says that the most intelligent men in the medical profession were the first to take positions in the army. I went early, but I went in the line. Found that was not healthy, then I found a position. Dr. Cowan is an old skeptic on microbes. Something of a moss-back myself, as age would indicate. Having been in the line of teaching for



the past twenty-five years, I have kept up with the progress of aseptic surgery. There were many reasons why we had success in the Confederacy. We had a good class of men to deal with. We had a class of men that it was almost impossible to kill. They had become so hard, so tough. The enemy even could not kill them. That was what he was trying to do.

Dr. Cowan was a field surgeon, like myself. Never in a hospital. We operated under favorable circumstances in the open air, where there were few microbe organisms, and, as a rule, if we got a case operated on with any decent skill, microbe organisms were excluded. I think my operations in the army succeeded as well then as they would now, and may be better, in most cases. I am a devotee to aseptic surgery. We have made much progress. I teach the Practice of Medicine, and I have often said that the rate of mortality now, under modern methods, is about as great as under the old methods. I have seen a good deal of proper scientific surgery in an institution which I have practical control of, all kinds of operations of brain, liver, and kidney, and I pledge you my word I have not seen a single suppuration in all of these. Then I must conclude that there is a great deal in modern aseptic surgery.

Dr. A. P. Fitch, Lebanon, Indiana: I am not a surgeon in the army, but I studied medicine and graduated since. But I want just to make a few remarks in regard to the question of Dr. Cowan. Of course I believe in aseptic surgery. I have followed especially the practice of that branch. I remember very well Dr. Miller who was wounded five or six times, and he got well. A little boy just six years old was shot over the eye. Dr. Miller merely wrapped a cloth around his head. He thought he would die in a day or two. The boy lived the next day, the next day, and so on. I do not think he used an antiseptic wash on that boy for nearly two weeks. He did not believe in aseptic surgery, and consequently the boy just lived. Of course we would think that was malpractice, and would so regard it. The boy being poor and Dr. Miller being a man of distinction, we will let that go by the board. The boy is paralyzed on one side. He is well to-day and going around, with still some paralysis of the left side.

The doctor asks, Why is it? Now, occasionally, we have results of that kind. It is not surgery. I want to say to the doctor that I was wounded twice myself in the war. The flower of the profession was in the Southern army, and the tail end of the medical profession was in the Northern army. I have never seen but one distinguished man who was surgeon in the Northern army. They did a good business at home, and did not care to leave.

During the Spanish-American war I went to the Governor of Indiana, and begged to go into the army. He knew me well, but he was a very radical republican, and flatly refused to give me a position, but sent a hospital student instead. As Dr. Cowan has said, the flower of the profession in the South went into the army, and that accounts, in a way, for the wonderful success, and we are proud of it.

Dr. T. R. Wingo, Trezevant, Tenn: Dr. Moore, speaking of Chickamauga, brings many things to my mind. I had gone to the front and had found some wounded. I was a jolly good fellow, and I won their hearts. Colonel Lewis and Major Bradshaw were badly wounded, and I got them into the ambulance. I changed my horses' position three times in less than an hour. Our curtains were riddled with bullets. They said, Doctor, do not let us be captured. We went to an empty house. We found a big five gallon white jug there, and guess what was in it. That jug was filled with clarified honey.

There was a gentleman named Johnson. You have all seen a Roman nose. Well this man had the biggest Roman nose I ever saw. Well he was shot in the nose, and it just took off the Roman part and left his nose straight. I dipped some pasteboard in hot water, and adapted it to the contour of his nose. I washed it as nice as I could, told him to go home, get plenty of fresh air, eat plenty, and keep clean. That man got well. I will tell you what I think helped that man to get well. He was a brave soldier, and I asked God to bless me in treating him. Three months after that he came back and shook hands with me, and said, "Doctor, I am glad to see you." I said, "I do not know you from Adam." He said, "Don't you recollect Johnson at Chickamauga?" I said, "You are not that Johnson. He had

a Roman nose." "I am the same man." I said, "That was the most fortunate shot you ever got. It just made your nose straight, and you are now a handsome man."

At Kenesaw Mountain there were some wounded, and some of them died from lack of water and something to eat. One man I operated on did not lose one drop of arterial blood. I asked the Lord to raise him up and bless what I did. That man went back to Virginia, and the devil could not kill him. I believe mightily in prayer in surgery, and then let the microbes go to the devil. I am a good soldier. I can prove it by Bill Allen down here. We were together four years. He lost his wife last April, and I never see that man that I do not hug him. Gentlemen, I was born in old Virginia, and my father was in the war of 1812. I did the very best I could, and the Lord God knows it. I am here, and I hope that you will never die, but that you will be carried to Abraham's bosom, and may your last days be like Job's. I had an uncle just before the war ninety-eight years old. I would like to live just two years more than that.

Dr. J. M. Keller, Hot Springs, Ark.: I am unable to say whether my friend is a Christian Scientist or not. He is against microbes. He leans very much to Christian Science.

My Governor, during the Spanish-American war, sent me up to Chickamauga to inspect. I knew he had no right to send me to make an inspection, unless I had a command from the general of the army. I reported and found Joe Breckinridge in command. I had on my blue uniform. He asked me what I was doing there. I told him I belonged to the militia, but that I was sent by my governor to look into the condition of your two regiments, "But I have come to you, sir," I said, "for orders." "I will make you look over more than two Arkansas regiments," he said. I told him that I had not the time. I got admission to all the hospitals over the entire campus. I was there four days, and was up till ten o'clock each night. I never saw more suffering from criminal neglect and from inexcusable ignorance than I saw in the fields and hospitals there. Among other things that I witnessed, there had been a committee sent on from Washington to report as to health conditions. Colonel Woodbury was chair-

man of it. They reported that the water in Chickamauga Creek was absolutely pure. I found on the second day that a large amount of fecal matter was emptied into Chickamauga Creek eighty feet above the intake. Now, all of this was taken rapidly into the water south of it.

I was talking with the surgeons in charge. The men were lying sandwiched on the ground in their uniforms, many of them without any shelter at all. There were whooping cough, pneumonia, measles, malarial fever, all mixed up together. They were deprived of everything on earth. While I was standing, talking with these gentlemen, one of them handed a thermometer to a nurse to take a soldier's temperature. The wrong end was put into the mouth. The nurse did not know the metal end from the glass end. I made my report to my governor, and it was sent to Governor Breckinridge, in which I stated that unless that encampment was broken up, there would be thirty thousand cases of typhoid fever in less than thirty days. He commenced to break it up, but even after that there were eighteen thousand cases of typhoid fever.

The following paper was then read by Dr. A. A. Lyon, of Nashville, Tenn.:

#### MALINGERERS.

*Mr. President and Comrades of the Association:—*

I notice that in the official circular sent out by the Secretary that the members of this organization are invited to present papers on this occasion that may contain some fact of the past in connection with their military service that shall be deemed worthy of preservation, etc.

This is rather a direct and personal proposition, and I am by no means sure, my comrades, that I am prepared to meet the indications. Nevertheless, I infer, and otherwise naturally conclude that a measure of latitude will be permissible here, that under a strict construction of rules, as usually applied to medical organizations, might be deemed somewhat out of order.

I recognize furthermore that anything like a learned disquisition or even quasi-learned disquisition involving specific scientific discussion on questions pathologic, diagnostic, therapeutic,

and above all bacteriologic, would scarce be acceptable on an occasion like this, when we meet more in the capacity of mutual entertainers, than in the rôle of medical masters and teachers of science.

In fact, I received a grim intuition from our esteemed Secretary, Comrade Roberts, that if I or any other man should prove audacious enough to say anything about "bugs" in this presence, that the offender would lay himself liable to immediate court martial, with prospective prompt conviction, and presumable prompt execution. And from the glint of the said Secretary's eye, it was clear to my mind that he would eagerly volunteer as one of the firing squad — and more than that, would claim a shotted gun.

Notwithstanding this, however, I beg to be permitted — by your grace — and by way of prefatory parenthetical injection *en passant*, merely to express a few thoughts in the generic on this terribly live subject of latter-day medicine, and to say that after spending the biggest part of quite a long life, with scarce an ailment of any kind vital in its nature, and, per consequence, in supreme mental serenity, I find now that in my declining years I am terrified by the modern bacteriologist and the terrible revelations he has latterly evolved touching the myriads of quadrillions of man-destroying monsters that he calls "microbes," that everywhere confront me, creep over me, crawl into me, that rush down my throat and into my wind-pipe, soak through my skin — thus into me, out of me, all over me. Thus am I possessed. I dream of them by night — and all the day long my meditations are of bugs, *Bugs*, BUGS.

I take up a text-book or a late journal and read tomes about bugs. The straddle bug and the bug that hops — the bug that wriggles and him that creeps — the tail pendent and the elongated — the stub tail and the tail turned up. We read of the social qualities and the domestic habits of these creatures; of the immense procreative capacity of the males and prodigious fecundity of the females. Every individual of this army is a human life destroyer. Well may we, in the face of such appalling conditions, borne down by a sense of desperation and a feeling of guileless despair, throw up our hands and exclaim, "Good Lord

deliver us!" And who could be surprised if this unwelcome query should obtrude itself? Can it be possible that Deity could have made a mistake when he created man and put him on this bug-smitten, mundane sphere?

And now, Mr. President, with an apology for this transgression, I will, with your permission, take up the report of two long ago *non* microbe cases that came within my professional purview while in the medico military service of the Confederate States in the far back sixties. Of course it is needless for me to say that at that date there was no suspicion of bug suggestions unless it be in connection with that ancient "humbug" that some unkind people are wont to say is characteristic of our profession and practice. But let this, for the moment, remain a question "subjudice."

The Great British General, Havelock, that flourished fifty years ago in the English or British army, states that out of every thousand soldiers there are seventy that will brave any danger and rush, as it were, into the very jaws of death. There are nine hundred that will follow after and do their duty; and that thirty will shirk a fight or other danger, if possible, and shirk whenever opportunity presents.

I think this is unmeasurably true of American soldiery also. So that not even all who wore the heroic gray wore it with honor or heroism.

Case 1. September, 1861, found me just out of school and established as an interne in the Louisiana (State) Hospital in Richmond, a species of "right bower" and factotum to the surgeon in charge.

During the winter the army of Gen. Jo Johnston was quartered near Manassas, or Centerville. A great deal of sickness prevailed in the army that season, and many deaths from measles, its pulmonary and other respiratory congenors. We were not surprised, then, to receive from the front a laryngeal case in the person of a foxy looking little fellow named Parsons. He did not look sick — on the contrary, appeared sleek and well nourished: always greeted us with a beaming smile that was ever soft and bland; complained of no pain in the throat, yet made fearful grimaces whenever he attempted to swallow, as though the effort

nearly choked. An examination revealed no local lesion that was visible, as we were not in that day so far advanced in laryngoscopy as we are at present. It was apparently manifest that the poor fellow had completely lost his voice. He would rise on tip-toe, stretch his eyes, and at our bidding open his mouth and try to yell, but the only sound that could possibly be evoked was a dismal, raucous huskiness, scarcely audible across the room. I had but a few months before emerged from the green-room, and was just beginning my practice. There were some things at that time that I did not know about pathology and diagnosis, and hence I was greatly mystified by these singular phenomena. I was acting as assistant to Dr. Felix Formento, of New Orleans, who was surgeon-in-charge, though himself quite young and inexperienced, though a gentleman of fine talent and accomplished education. I naturally worked up to him.

I shall never forget the graceful assurance of my admired superior as he turned to me, after a long siege of our diagnostic gymnastics, and said, with supreme complacency, "Doctor, we have here a very interesting case of aphonia." I am not sure I had ever heard the term before, but of course I accepted it as seemingly a very pronounced case of something, whatever it may have lacked in interest. So we began treatment. Dr. F. prescribed and I executed. We sprayed him, rubbed him, iodined and blistered him, anointed and swathed him, and gargled him, "*secundum artem ad infinitum*," but without the slightest benefit, so far as we could discern. And do what we could, the poor man's voice seemed beyond the reach of recovery. At last he suggested, after some weeks of heroic treatment, that as a soldier he could not be of service devoid of the power of articulation, and intimated that the cause of the Confederacy would probably be advanced by giving him a discharge. This was not at first encouraged, but finally the surgeon in charge, yielding to a seeming inexorable necessity in the face of incurable and disabling disease, and as soldiers were really plentiful then, the necessary papers were formulated, and our unfortunate patient was liberated from the bondage of war. Smiling and bowing to the last, he bestowed his whispered thanks, and marched out of the hospital. We felt chagrined at our unhappy failure to cure



this case, but nevertheless concluded that in the action taken we had simply made a choice of evils.

I never saw him afterwards, but twenty-four hours later the sleek scamp had procured a basket of gim cracks of some kind, and was mounted on a dry goods box in the streets of Richmond, auctioning off in most voluble style his wares, as I was readily informed. He belonged to a Louisiana regiment, the number I do not remember. Just twenty years later, in 1881, I was dining with my esteemed friend and quondam chief in New Orleans, and ventured to reopen this subject in the presence of a number of other guests. I am not sure, however, that the doctor had even then fully recovered from the shock of that experience.

Case No. 2 was in the person of a big raw-boned, freckle face, red-headed fellow by the name of Guess. He was brought to my regiment, the Forty-eighth Mississippi, as a conscript late in the fall of 1862 or 1863. He was a rough, strapping fellow, fished out somewhere from the knobs and hills of Mississippi, and to all appearance possessed every physical element of a vigorous soldier. With him came a small squad of his neighbors. They were assigned to Company K, at that time under the command of Lieutenant Tom Lipscomb, an intrepid, dare-devil fellow who was afraid of nothing, and who detested a shirker anywhere, and especially in war.

Soon after the arrival of this party, I was hurriedly summoned to camp to see Guess, who "had a fit." I responded immediately, and found the unfortunate fellow recovering from a convulsive paroxysm, and being asked by the sergeant if he was able for duty — picket duty that morning — I excused him. A few days later another early hour call to "Guess, with a fit." This time the convulsion was more prolonged, and a suspicion arose in my mind that our conscript officers had not been altogether circumspect in their selection of soldiers for the Virginia army. Still another fit followed, in a brief period, and I noted one circumstance in connection with these exacerbations, and it was that they seemed to occur about the hour in the morning that the picket detail was made. Again an early call to see Guess. I found him in a terrible convulsion, and his friends in great concern were rubbing and otherwise ministering to him. He was



in some respects a fine dissiminator, but I began to grow suspicious. I was suspicious, after careful examination, that there were considerable signs of the "old soldier" in the case. I, however, called in Dr. M. S. Craft, who was our brigade chief, as consultant. Dr. C. stooped down and inspected him closely, and turning to me, said, "Lyon, I believe he has a fit." Thus he was excused again. But further investigation and very close observation on my part later satisfied me that the wretched fellow was a dissiminator absolute. So I decided on a course of radical treatment to meet the exigencies of this case.

We were bivouaced on a gentle hillside for a few days in Northern Virginia, between Winchester and Martinsburg. It was in November, and the nights were quite cold. At the foot of this hill was an immense spring, said to be bottomless, and perhaps thirty to forty feet square. So one morning I said to Lieutenant Lipscomb that I was satisfied that Guess was "playing off," and I would prescribe something curative if he would promise to apply the remedy. This he assured me he would gladly do. I was the surgeon in charge this time, and carried the authority that we all recall pertained to that office. Said I, if another fit develops order four men, take Guess by his legs and arms, and throw him bodily into that spring, and I will assume responsibility for consequences. Promptly the promise was made.

A few mornings later the Lieutenant came running to my quarters, in a state of gleeful enjoyment, with the exclamation, "Guess is cured."

"What!" said I, "Did you throw him in the spring?" "Not exactly, but something as good." "I came upon the scene," he continued, "found him stretched on his back, the anterior of his person, from chin to pubis, exposed, while the boys were rubbing and trying to bring him too. His head was up hill, and his eyes, as usual, closed. Taking in the situation, I seized a horse bucket, nearly full of water, that had been sitting on the ground all night and was frozen over. With a sudden dash I inundated him from his chin to his nether extremities. With a spasmodic jerk and a Commanche yell, he bounded to his feet. The treatment was instantaneously effective." To all appearance the cure

was so absolute that the late victim to eclampsia was deemed well enough to do any kind of military duty. On this occasion he was promptly marched to the picket post. But, alas, for the sequel! Guess disappeared as completely as if swallowed up by the earth. We never heard of him again, but the unavoidable conclusion was that under the cover of darkness he had crossed over the Potomac River and proceeded to rest under the umbraguous shadows of the other side, where bullets ceased to fly and fits need never come.

It is a source of gratification that such characters as these two described were rare in our army — so rare, indeed, as in no particular to give even the slightest flavor of taint to the magnificent hosts that fought beneath the ensanguined stars and bars of our heroic Southern Confederacy.

After the reading of the above paper the Executive Committee retired to select officers for the ensuing year. President Gildersleeve announced on their return that the Executive Committee begged to report the list of officers which was published in our July number, page 429, who were unanimously elected.

Dr. Gildersleeve (Retiring President), then said:

Gentlemen: It becomes my duty now to induct into this office my successor, Dr. Cain. (Dr. Cain was then introduced by Dr. Gildersleeve). "It is my pleasant duty to proclaim you President of this Association, and in extending to you this gavel, the emblem of your authority, I feel sure that you will wield it wisely and well in the interest of this Society. Accept my congratulations and best wishes.

Dr. John S. Cain, Nashville, Tenn.:

*Gentlemen of this Association:*

I seldom allow myself to be embarrassed, but still there are circumstances and conditions which have a tendency to rather produce that effect. This is one of them. I have held some positions of honor in associations of various kinds, but, as my good friend Cowan said just now, this is probably the highest one I have ever had bestowed upon me. I so appreciate it and so feel it. I was not expecting this, gentlemen. If I had had any inti-

mation of it, I would have had a little impromptu speech prepared. I did not have my lightning rod up, as I did not expect to be stricken this way, consequently this finds me unprepared with words to express my feelings on this occasion. While I have been a member of this Association for some time, this is the first meeting I have ever attended, so it finds me ignorant of my duties. Probably that will insure the Association against my doing anything rash or imprudent. It had that effect on me when I commenced practicing medicine. I commenced very young, almost a boy in years. I was soon made to appreciate my ignorance, when I was brought face to face with disease and death in those few paupers who saw proper to patronize me. The result was I did very little for my patients, and a second result was they nearly all recovered. Later on, when I became more efficient and more confident, the results were not so favorable. It may have this effect in this instance. I certainly will not attempt to do anything very radical, but will endeavor to follow in the steps of those illustrious gentlemen who have preceded me. Gentlemen, I can only say that I will endeavor to do my duty faithfully. I feel fully impressed with the responsibilities of this high and honorable position and the only thing I can promise you is to faithfully and honestly endeavor to discharge the duties of this office.

Dr. Keller moved that a badge be adopted, a small, plain gold star, with the letters C. S. A. on it, which every member and associate member shall be entitled to wear. Seconded and carried.

Dr. Keller made a motion that Dr. Plunket be made a committee of one to investigate the purchase of this badge. Seconded and carried.

Dr. G. H. Tichenor made a motion that the button be copyrighted. Seconded and carried.

Meeting adjourned until 1:30 P. M. Met at 1:30, but had to adjourn in a very short time to allow those present to attend a special service at the Centennial Park. Meeting called for 5:30 P. M.

Meeting opened at 5:30 P. M., with Dr. Cain in the chair.

Dr. J. B. Cowan, of Tullahoma: Dr. Tebault has prepared some of the best historical papers of any man in the South. He has worked them out through every channel and through every avenue to get at facts. He has read those papers, and has had them put in print. Not only that, but he has refuted slanders that have been perpetrated upon the South, and almost believed in the South, because no man has come up to refute them. He has written and presented the proof, and has hurled the slanders back to where they emanated, until he has brought those men to silence, and has proved false the slanders that they have perpetrated. He has some papers to submit to this Association at this meeting. I think it is a misfortune to this Association that he is not here. He is the successor of Dr. Joseph Jones. I think Dr. Jones is the most remarkable man the Southern country, or any other country, has ever produced. He was an illustrious man. He worked without ceasing to the last moment. Let me give you a little record of that man. For twenty-one years he never missed a day walking the wards in Charity Hospital in New Orleans. Sometimes lectured in the University, and all the time had a large practice outside. His wife said to me at his own office, "I wish you would persuade him to sleep more than he does. He sits up and reads until one and two o'clock every night." I have been at his home several times. He was a congenial, grand old fellow. Dr. Tebault is Dr. Jones' successor. One of the grandest men I ever saw. He has working quality. We made him Surgeon-General of our Association. That was the best appointment we ever made. Now this is the man I would not like to see this meeting close without your hearing him. He is not like I am. When he speaks it comes as clear as a bell. Now, gentlemen, I wish to say this in Dr. Tebault's absence. He has contributed more to the medical history of the Confederacy and to the history of the South than any other man.

Now, gentlemen, in regard to this Association, we are a little out of joint. The records are not present, and we do not know just where we are, because they can not be secured.

I am glad to see Dr. Cain made President. We started out together at the bottom, but I fell by the wayside. Without re-

ward Dr. Cain has built up one of the very best medical schools of the South, at Sewanee, Tenn., and is at the head of it to-day.

Now, gentlemen, there is one thing else. We are passing away very rapidly. Every incident that occurs, every personal experience that goes to make up history, should be recorded now. When we die, it will be too late. The day we organized a resolution was passed that every paper read before the Association should be put in one particular place. They should be filed in the archives in New Orleans. I understand that some of the papers have not reached there. They must be put there. That paper read yesterday is worth thousands of dollars to medical work in the South. That paper ought to go to that place to be used as historical matter hereafter. Now there are a thousand things along that line that we ought to preserve for history. We are all busy men. If we would spend only two or three hours in the year to write down these incidents that occur, we could place them where they could be preserved and reached.

Dr. J. D. Plunket: There has been an inquiry in my mind for some time. I would like to get information from somebody about it. I was not at our last meeting. It is along the line that Dr. Cowan has just spoken about. What has become of the papers of Dr. S. H. Stout, Medical Director of the Hospitals of the Army of Tennessee? They were prepared, as I understood, for publication. I would like to know something about these papers.

Dr. Cowan: I believe I can answer that inquiry. The Doctor wished to put the matter in book form, but did not have the means. The matter was brought before this Association, but we had no money in the treasury. I think his family still have all the records, and it might be well to correspond with his son or daughter living in Dallas, Texas.

Dr. Plunkett: I want to thank the gentlemen severally for the information they have given me. It has brought up a new line of thought to me. The family have all scattered, lost all special interest, no doubt, in this matter, and this Association ought in some way to secure these invaluable papers, and have them filed in the archives at New Orleans without delay.

Dr. Gildersleeve moved that the thanks of the Association be extended to the ladies of Nashville for their presence, and the delicious lunches each day served our Association, and that the thanks of the Association be extended to the University of Tennessee for the use of its building as a place of meeting, and especially to the Nashville Academy of Medicine, whose guests we are, for their kind hospitality extended to the Association in many ways during our meeting here. Adopted.

Dr. Newton offered a resolution of thanks to the retiring President. Adopted. •

Dr. J. D. Plunket, from Committee on Badges, asked for further instructions. Since the forenoon meeting, he stated, the committee had obtained bids from two of our leading jewelers, and they were the same for lots of one hundred buttons.

(a) Gold. One dollar for each button.

(b) Silver and other metals. Fifty cents for each button.

The committee would suggest that for the sake of securing entire uniformity in the badge to be worn by our members, that not only the design, but the character of metal, be specified by the Association, so all shall be alike. Again, at this time, it is impossible for your committee to know exactly how many members will take one of the badges. This it is important for them to know, so that they may be thus guided in placing their order for the badges.

Dr. J. B. Cowan moved that the committee correspond with all absent members, and get definite information as to whether they will take a badge, or not, and report to the next meeting of the Association, a year hence.

Dr. Tebault, arriving upon a belated train, then appeared and read two very interesting papers before the Association, printed copies of which were promised to all members of the Association.

The Association then adjourned sine die.

## *Obituary.*

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FRANK A. WALKE, M. D.

Since our last number was issued we have learned of the death of Dr. Frank Anthony Walke, which occurred at his residence in Norfolk, Va. He entered the Confederate army as a private soldier early in 1861, serving as such for two months, when he was appointed Surgeon of the Sixth Virginia Regiment, serving in that capacity throughout the entire war between the States from 1861, until he was paroled at Appomattox C. H.

He was able, efficient, and faithful in the discharge of every duty. After the surrender he practiced in Norfolk until his death last month, being highly esteemed by a large clientele.

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H. J. WARMUTH, M. D.

From the Nashville Banner of the 13th inst. we learn that H. J. Warmuth died in Philadelphia, Pa., where he had gone for treatment.

Dr. Warmuth was one of the most prominent physicians in Rutherford County, having practiced his profession in that county around Smyrna for forty-five years. He was a member of the Georgia regiment, and was put in charge of a Confederate hospital near Smyrna during the civil war. After the war he resided there, and married Miss Mary Peebles, daughter of a prominent farmer in that county. Dr. Warmuth leaves only two children, a daughter, Mrs. J. D. Love, of Nashville, and one son, M. P. Warmuth, of Philadelphia, at whose home he died.

From his record blank filed as a member of the Association of Medical Officers of the Army and Navy of the Confederacy, we get the following facts: Born in the city of Mexico, Jan. 1840. Entered the C. S. A. as a private in the Ninth Georgia Infantry; was appointed Assistant Surgeon, and on March 23, 1862, was promoted to Surgeon and assigned to the Ninth Georgia Infantry. After the battle of Chickamauga was transferred to hospital duty at Marietta, Rome, and Covington, Ga. At his

quest, in March, 1864, was transferred to the Seventeenth and Eighteenth Texas Infantry, Granbury's Brigade, Cleburne's Division, and later to the Thirty-seventh Georgia Regiment. Ordered by General Forrest to take charge of hospitals between La Vergne and Murfreesboro, and after convalescence of the men under his charge was sent to prison at Ft. Delaware, and released Aug. 1, 1865. A good and faithful soldier and an efficient surgeon.

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## *Editorial.*

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### A BRIEF COMPARISON.

Hearing recently a very excellent sermon by a gifted young preacher in this city in one of our leading churches, his text being "The Sixth Commandment," in which some statistics were indulged in showing the great loss to the State, as well as the injury inflicted on unoffending, helpless and in no way responsible members of a community by its violation, the thought occurred that if more time and attention were given by our clergy, our law-makers, and the executives thereof, and their associates of the Bench and Bar in the line of securing a better observance of the seventh commandment by our whole people, both the individual and the commonwealth would be greatly benefited.

Now let us indulge in a brief and somewhat cursory manner in a little comparison which, though "it may be odious" is none the less true. The youthful mind is early trained and taught as to the heinousness of taking human life, the crime being fully and lucidly explained early in life; but how about the seventh commandment? He or she reads it, or has it read to them, briefly, hurriedly, and shall I say it? yes, skimpingly. Granted he or she gets to understand it as the days roll by, but never has the stress been put on it as on its numerical predecessor.

The oldest law demanded "a life for a life," and our later and most improved "statutes" fix a penalty of "death," "imprisonment for life," or for a definite term of years, and a great proportion of our criminal expenditures, both as to conviction and execution, are required to prevent a violation of the one—and how about the other? Oh, yes! we have "statutes" bearing upon it; but when are they executed or enforced? We have an unwritten law that sometimes gives the life of the male offender into the hands of a male relative of the female. But what are the *facts*?

Our ministerial friend in his sermon very correctly stated that it "was not only a violation of the sixth commandment to take the life



of another wilfully, or in anger, but even accidentally, or the destroying one's own life by suicide or even neglect of the common laws of health as now understood." His facts and figures showing the number of murders and suicides in recent years were being so alarmingly on the increase that the value of human life was greatly depreciated, and that it was held too cheaply.

Yes, murder kills its thousands, but the other, far more than its *ten thousands!* We give in our department of "Selections" this month a very pointed article from our red-back contemporary, *Dan's Texas Medical Journal* that is fully in accord with the latest and most authentic observation, and to which we respectfully refer the reader.

By the hand of a murderer, a widow and helpless children may be left to scramble for a living—but they rarely starve to death, at least not in this country. Violation of the seventh commandment opens many short and full length graves.

• Observance of the seventh commandment by the male and female members of a community or a commonwealth will eradicate venereal diseases therefrom; than which the "Pale Rider" has no more efficient ally, and by which the population of our poor-houses, our blind asylums, and our insane hospitals are very materially increased, as well as the vilest form of murder, criminal abortion.

The civilized world to-day sadly needs that the time and talents of its clergy, its bench and bar, its political economists, as well as its law-makers should be devoted to some extent to a more careful consideration of a subject of most vital importance to both the nations of the earth and the individual citizens thereof.

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#### "THE AMERICAN WAY."

In a special department of last Sunday's issue of the *Nashville Daily American* entitled "Sunday Morning Gossip," and under the shadow of Will T. Hale's pen, who by the way, is one of the present day's most forceful, graceful, and interesting writers in our beloved Southland, we find a most timely and practical suggestion in the issue of Aug. 21, with the above heading. As all our regular readers are doctors, and necessarily sanitarians, it should be to them sound and practical teaching—not that they do not know it, but its observance by them in practice and precept will do much to lengthen the days of themselves and their clientele. The sanitary "tid bit" is as follows:—

"It is asserted that the Japanese, especially the women, are unusually good-natured. They are never 'soured.' The reason is that they never let anything worry or fret them. No trouble with the servants; no anxiety or ambition regarding gowns that will 'kill' a neighbor with envy.

We might learn from the Japs. With Americans all is anxiety,

fret, nervousness. Take for an instance the suburbanite. When he goes to bed he wonders if he will awaken in time to get off to his business in town on the 7 o'clock train, and perhaps he dreams of being left. When he gets up, he hurries with his attire, bolts his breakfast, and rushes to the station. The train is five minutes late, and he pictures the wrath of his employer when he shall reach the shop. Safely inside the coach he happens to discover his umbrella. 'Now I wonder if I will rush out when we reach the station and leave this?' he frets. By four in the afternoon he feels a desire to spend a long evening with the friends who are visiting at his home; 'but, ten to one, the 6 o'clock flyer will be an hour late,' is his inward comment. And so it goes, from matters of no moment to things of importance. It is making life short; it is converting us into pessimists, which is—worse."

Yes, it is the little ills that kill—rush and worry in this day and time are more "harmful to the public weal" than epidemic visitations.

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#### "REDUCE THE DUES."

In the August number of the *Memphis Medical Monthly* the leading editorial has the above heading, and from which we quote the first paragraph, heartily endorsing it.

"In a recent issue of the *Monthly* we editorially advocated a reduction in the annual dues of the Tennessee State Medical Association from the present sum of two dollars to an amount more within the reach of the profession in general. This argument we note has given rise to considerable favorable comment, and we believe that it will receive strong support at the next meeting of the State Association."

When the new constitution and by-laws were adopted at the meeting in Memphis, over two years ago, we earnestly advocated fixing the annual dues of the State Association at the sum of one dollar, believing at the time, as we have been subsequently convinced, that it would suffice for the necessary expenses of the Association. What we need is a "Tax or Tarriff for Revenue Only," believing it to be both unwise and unnecessary to require more from the members than a sufficiency to pay the expenses of the Association, economically administered. This, as we said, we believed at that time, and now know, would only require a per capita tax or assessment of one dollar for each member. Those who advocated a higher tax at the time, claimed that the Association was in debt, and that if after the debt was cancelled, and we found that one dollar per annum from each member would suffice to meet the necessary expenses, we could easily reduce the assessment. This time has now arrived, and we sincerely hope that our able contemporary in Memphis will continue his efforts in this direction, promising to aid the measure so far as we possibly can.

The State Medical Association is in a certain sense a post-graduate medical school of the highest order, to which each member can bring

his contribution, and receive his share of the benefits. Medical organization is now in better shape than at any time in the history of the profession in the State. We sincerely believe that if our advocacy had prevailed at the last meeting held in Memphis, that the Association now would have had a larger membership than it has. With a reduction of the assessment, we heartily believe that its large membership will be far more increased than by any other measure. If when we succeed in increasing the membership to the highest possible number, and we then find an additional amount each year is needed, it can be changed. As it now stands, we assert from information in our hands, that one dollar per capita will suffice for the expenditures that may be necessary for the ensuing year, consequently we will endeavor to secure the reduction at the next meeting, and believe and hope that we will be sustained by the members of the Association.

By making the assessment too high, it becomes prohibitive. What we now need, is to have every reputable member of the medical profession in the State a member of his county society and thereby a member of the State Association. This we cannot accomplish if we hold the annual assessment higher than is necessary.

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#### INCORPORATION OF THE AMERICAN MEDICAL ASSOCIATION.

At the last meeting of the American Medical Association a committee was appointed to take the necessary steps towards securing incorporation of the Association under National enactment. The following letter has been received from the Chairman of the Committee, which we sincerely and earnestly hope will meet the approval of every reader of this journal, and most respectfully request each one to at once write to his representatives in the national House and Senate asking his support of the measure.

*No. 32 West 48th Street,  
New York, N. Y.*

DEAR DOCTOR: I am again calling the attention of the members of the House of Delegates to the need of active effort on their part, in securing the weight of co-operative action of the members of the American Medical Association in gaining a national incorporation of the organization at Washington the coming winter. The following is the text of the now proposed charter of incorporation as just constructed by Judge Ray, who is still giving us the benefits of his long experience in such matters. (See report of Committee on National Incorporation, *Journal American Medical Association*, June 11, 1904.)

"Be it enacted by the Senate and House of Representatives in Congress assembled:—

"Sec. 1. That Robert M. O'Reilly, M. D., Presley M. Rixey, M. D., Walter Wyman, M. D., E. H. Gregory, M. D., Henry O. Marcy, M. D.,

Nicholas Senn, M. D., George M. Sternberg, M. D., J. M. Matthews, M. D., W. W. Keen, M. D., C. A. L. Reed, M. D., J. A. Wyeth, M. D., Frank Billings, M. D., J. H. Musser, M. D., T. J. Happel, M. D., Miles F. Porter, M. D., E. E. Montgomery, M. D., W. W. Grant, M. D., H. L. E. Johnson, M. D., A. L. Wright, M. D., William H. Welch, M. D., M. L. Harris, M. D., and Philip Marvel, M. D., and their successors, are hereby made and constituted a body politic and corporate by the name American Medical Association, with perpetual succession and power to take, for the purpose of its incorporation, by devise, bequest, grant, gift, purchase, or otherwise, and hold or convey both real and personal property, and transact business, anywhere within the United States

"Sec. 2. The object and purpose of such corporation shall be to promote the science and art of medicine throughout the United States.

"Sec. 3. Such corporation shall have power to make by-laws, rules and regulations, and choose officers for its government and the attainment of its purposes."

You will please to arrange it with your colleagues of the House of Delegates of your own State, that the president and secretary of each county organization of the State receive promptly a copy of the enclosed petition along with an urgent request that the signatures of the members of each county organization be promptly signed and returned to you, (that you may know at once of compliance with your request,) for compiling and forwarding to me not later than November 1st, 1904, for presentation at Washington at the opening of the Congressional session. Many of the State organizations have already taken active steps in the matter in accordance with the spirit of the following resolution passed at the last meeting of the American Medical Association at Atlantic City.

"*Resolved*, That the officers and the members of the House of Delegates of the American Medical Association now in session at Atlantic City, do hereby pledge their loyal support and earnest efforts in aid of securing national incorporation of the American Medical Association by a special act of Congress."

Yours truly,

JOSEPH D. BRYANT, M. D., *Chairman*

*Committee National Incorporation.*

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DR. PETTEY'S WESTERN RETREAT.—Having met with such signal success in his Memphis institution for the treatment of alcohol and drug addictions, and since there is a strong demand for institutions of this kind conducted within ethical lines, Dr. Pettey has opened a Retreat at 1939 East Evans Avenue, Denver, Colo., and soon will open another at Atlantic City, N. J.

These institutions will be under the management of physicians who have been associated with Dr. Pettey in this line of work at his Memphis Retreat and who are thoroughly familiar with his methods of treatment,

and with the care and management of this class of cases. It has now been three years since Dr. Pettey published to the profession a successful treatment for the narcotic drug addictions, and, he says, since others seem so slow to prepare for and take up this line of work, he feels justified in attempting to meet the demand for treatment by the methods he has introduced by opening these additional institutions. He assures the profession that they can depend upon the treatment at his branch retreats being kept up to the same standard as that administered under his immediate supervision.

Dr. Pettey is one of the few physicians engaged in this line of work who does not advertise to the public direct, and whose methods are entirely open and ethical. We bespeak for his Eastern and Western Retreats the same hearty professional support that has been given his Memphis Retreat.

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TREATMENT OF CHRONIC ULCER OF THE LEG OF LONG STANDING.—At the beginning of the present year I was called to a woman, aged fifty-four years, who had a chronic sloughing ulcer for twenty-two years situated on the outside of the left leg, some ten inches long and three inches wide, with indurated edges and some thrombosis of the veins of the inside of the knee. Having first cleansed the ulcer with charcoal poultices for two days, I applied wet butter cloth and then spread Antiphlogistine over it, after which cotton wool and a bandage were put on. This was done every day by the patient's friends for four months. The ulcer is now quite healed over and the induration is all gone. She is able to resume her ordinary housework. I publish this case in the hope that it might be useful to others, as Unna's paste and all sorts of methods had been previously tried. I may say that I have no personal interest in Antiphlogistine.—*Horatio W. A. Cowan, M. B., C. M., Aberdeen, in London Lancet, July 2, 1904.*

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ADRENALIN, the active principle of the suprarenal gland, is unquestionably the most powerful known astringent, hemostatic, and cardiac and vasomotor stimulant. Its action is almost magical. Its therapeutic applications are exceedingly numerous and constantly increasing through experimentation. Extremely satisfactory results have followed its use in diseases of the nose and pharynx, and in laryngitis and otitis media.

Medical reports show that the best results are obtained in the treatment of hay fever by the frequent use of *Solution Adrenalin Chloride*, 1:5,000 to 1:20,000.

In response to a demand from the medical profession, we announce two new Adrenalin preparations, *Adrenalin Inhalant* and *Adrenalin Ointment*.

*Adrenalin Inhalant* is an excellent application in inflammatory affections of the nose and throat. It is composed of Adrenalin Chloride,

1 part, and an aromatized, neutral oil, 999 parts. *Adrenalin Inhalant* is supplied in one-ounce, glass-stopped vials.

*Adrenalin Ointment* consists of Adrenalin Chloride, 1 part, and enough of a bland, oleaginous base to make 1000 parts. *Adrenalin Ointment* is adapted to the treatment of inflammatory conditions of the mucous membranes of the nose, eye, urethra, and rectum. It is supplied in collapsible tubes provided with an elongated tip to facilitate introduction into the nose, urethra, external ear, etc. Write to Parke, Davis & Co. for particulars, either at Detroit, New Orleans, Memphis, or Kansas City.

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A SCOTCH DOCTOR'S OPINION.—*The Quarterly Journal of Inebriety*, so well and favorably known through the instrumentality of its brilliant and philanthropic editor, T. D. Crothers, A. M., M. D., quotes the following statement in reference to pain relieving remedies, from one of Great Britain's noted medical men, Dr. John Stewart Norvell, Resident Surgeon Royal Infirmary, Edinburgh: "Antikamnia Tablets are a remedy for almost every kind of pain, particularly for headaches, neuralgias, and neuroses due to irregularities of menstruation. They act with wonderful promptness; the dosage is small, two tablets. The undesirable after-effects so commonly attending the use of other coal-tar analgesics are entirely absent and they can therefore be safely put into the hands of patients, for use without the personal supervision of the physician."

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WHEN THE MENSES ARE SUPRESSED from exposure or from colds, wet feet, the result of emotional excitement, or febrile conditions, if not complicated with organic change, but by a mere passive congestion, Aletris Cordial Rio is a very reliable remedy. It is an emmenagogue, not abortifacient.

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NEW ORLEANS POLYCLINIC:—*Eighteenth Annual Session opens November 7, 1904, and closes May 20, 1905.* Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory and cadaveric work.

For further information address, New Orleans Polyclinic, Post-office box 797, New Orleans, La.

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CATARRHAL DEAFNESS.—David Fawdrey, M. D., Waterton, N. Y., writes as follows: "A young man twenty-two years old, a student in the Buffalo University, consulted me for chronic catarrh of nose and inner ear. This trouble was so bad that the patient could not hear a watch tick when placed against the ear on the right side. The left ear would

catch a faint tick at six or eight inches. The nose and ear had received treatment from some of our best specialists with little or no improvement. I placed the case on Glyco-Thymoline to be used three times a day in the nose with nasal douche and a tonic of Elix. Calsaya Strych. and Iron, and the improvement was marked in a few days. The hearing is nearly normal and he is still using the Glyco-Thymoline daily with steady restoration of health in both nose and hearing. I am opposed to the majority of proprietary medicines, but in this case much has been accomplished and I firmly believe will produce a permanent cure."

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TRI-STATE MEDICAL SOCIETY OF ALABAMA, GEORGIA, AND TENNESSEE.—The Sixteenth Annual session of the Tri-State Medical Society of Alabama, Georgia, and Tennessee will be held at Chattanooga, Tenn., Oct. 12, 13, and 14, 1904, under the presidency of Dr. F. B. Sloan of Cowan, Tenn. The headquarters will be at the Read House.

Addresses will be delivered by Dr. William J. Mayo of Rochester, Minn., and Dr. A. J. Ochsner of Chicago.

Requests for places on the program, or information in regard to the meeting can be had by addressing the Secretary, Dr. Raymond Wallace, Loveman Building, Chattanooga, Tenn.

The usual railroad rates will be in effect.

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## *Reviews and Book Notices.*

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INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Pathology, etc., and the allied branches of medical and surgical science, by leading members of the medical profession throughout the world; edited by A. O. J. Kelly, A. M., M. D., Philadelphia. Vol. II, 14th; series 1904, 8vo, cloth, pp. 314. Price \$2.00. J. B. Lippincot Co., Publishers, Philadelphia, Pa.

The July, 1904, number of the International Clinics is unquestionably an exceptionably good one; the first part of it being devoted to diseases of warm climates is of more than usual value. There is so much to commend in this volume that we can but regret that space will not permit particularization; however, we can unhesitatingly say that the articles are timely; they are practical, with more than ordinary originality, and the illustrations elucidate, and it is worth far more than the cost price of only two dollars.



THE SUMMER DIARRHOES OF CHILDREN, THEIR ETIOLOGY, PATHOLOGY, AND TREATMENT. By H. Illoway, M. D., formerly Professor of Diseases of Children, Cincinnati College of Medicine and Surgery; formerly Visiting Physician Jewish Hospital; one of the collaborators American Text-Book of Diseases of Children, etc., etc. 12mo, cloth, 1904. E. R. Pelton, Publisher, New York.

This is a very excellent little monograph on a most important subject, which we can most heartily commend. His views on the pathology and etiology of the disease we thoroughly endorse, and his measures of treatment established thereon are, in our opinion, most correct. It is but a little book, but *valuable*.

TRANSACTIONS OF THE AMERICAN ROENTGEN RAY SOCIETY. Fourth annual meeting held at Philadelphia, Dec. 9, 10, 1903. 8 vo, cloth, pp. 259. Murdoch-Kerr Press, Publishers, Pittsburg, Pa., 1904.

We find here the constitution and by-laws, list of members, and a full report of the last meeting of this society, together with some very interesting and valuable papers read at the meeting.

The membership comprises about 250 prominent members of the medical profession located in different states of the Union, most of whom had obtained some prominence along special lines, notably those connected with electro-therapeutics before the development of the Crooke's tubes and their great value had become apparent.

Dr. Jas. B. Bullitt, of Louisville, Ky., is the President of the Society, with Dr. Jno. B. Murphy, of Chicago, and Edmund E. King, of Toronto, Vice-Presidents, and Russell H. Boggs, M. D., of Pittsburg, Pa., Secretary.

CLINICAL TREATMENT WITH PATHOLOGY AND TREATMENT OF DISORDERS OF METABOLISM AND NUTRITION, by Prof. Dr. Carl von Noorden, physician in chief to the city hospital, Frankfort a Main. Authorized American edition. Translated by Boardman Reed, M. D. Part V, Saline Therapy. 8 vo, cloth, pp. 92. E. B. Treat & Co., Publishers. New York, 1904.

This little monograph consists of the observations and investigations of Prof. von Noorden, and Dr. Carl Dapper of Kissen-gen, and in view of the importance of balneological therapy and the action of the salines, will prove a valuable addition to the medical literature of the day.



**THE MAN WHO PLEASES AND THE WOMAN WHO CHARMS**, by John A. Cone, 16mo, pp. 131. Hinds & Noble, Publishers, New York. Price 75c., 1904.

The author has made a fair and favorable presentation of those qualifications that go to make up the manner and art of pleasing. It may be studied as well as read with both pleasure and profit, and presents the characteristic needs of the present generation, and has a direct bearing on the amenities of daily life and intercourse with our fellows.

**ELECTRO-DIAGNOSIS AND ELECTRO-THERAPEUTICS.** By Dr. Toby Cohn, nerve specialist of Berlin. Translated from the second German edition and edited by Francis A. Scratchley, M. D., of New York. With eight plates and thirty-nine illustrations. Cloth, 280 pages; price, \$2.00. Funk and Wagnalls Company, New York and London, 1904.

This is an authorized translation, with reproductions of the original plates, of the most popular German manual upon the kindred subjects of the diagnosis of disease and its cure by the use of electricity. Its author, Dr. Toby Cohn, of Berlin, is a practical instructor in these branches, and wrote the work to satisfy an imperative need in his classes. Dr. Mendel, of the University of Berlin, the well-known authority upon Electro-diagnosis, pays the highest possible tribute to Dr. Cohn by noting the "interest and enthusiasm" of his students, and the "excellent and practical results" of his instruction.

The character of the work as an object-lesson text-book is greatly enhanced by the eight anatomical plates, with coverings of transparent paper upon which are indicated in red the points of application of the electric current. The book is thoroughly indexed.

**A TEXT-BOOK OF PATHOLOGY**, by Joseph McFarland, M. D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College of Philadelphia; Pathologist to the Medico-Chirurgical Hospital, Philadelphia. Handsome octave volume of 818 pages, with 350 illustrations, a number in colors. Cloth, \$5.00 net; Sheep or Half Morocco, \$6.00 net. W. B. Saunders & Co., 1904, Philadelphia, New York, and London.

It was with anticipations of much pleasure and interest that the reviewer began reading Dr. McFarland's work on Pathology, and he can truthfully say that his greatest expectations were more than fulfilled. The book is excellent — excellent as regards both

text and illustrations. Of the latter there are a number of beautiful ones in colors, printed directly in the text. Dr. McFarland's thirteen years' experience as a teacher of this subject, besides his extensive personal research in the laboratory, has fitted him most admirably to write a text-book on pathology, and this superb, forelying work is all that any one — student or practitioner — could desire. Unlike most works on pathology, the subject is treated, not from the professor's point of view, but from that of the student, the many difficult theories of the science being explained in clear, concise language. Quite a few works on pathology have come to the reviewer's desk within the last few years, but none has reached the standard of excellence held by Dr. McFarland's work.

**THE PRACTICAL APPLICATION OF THE RONTGEN RAYS IN THERAPEUTICS AND DIAGNOSIS**, by William Allen Pusey, A. M., M. D., Professor of Dermatology in the University of Illinois; and Eugene W. Caldwell, B. S., Director of the Edward N. Gibbs Memorial X-Ray Laboratory of the University and Bellevue Hospital Medical College, New York. Second edition, thoroughly revised and enlarged. Handsome octavo Volume of 690 pages, with 195 illustrations, including four colored plates. Cloth, \$5.00 net; Sheep or Half Morocco, \$6.00 net. W. B. Saunders & Co., 1904, Philadelphia, New York, and London.

This excellent work has attained the distinction of two large editions in one year — a proof not only that such a work was needed, but also of the book's practical value. The vast amount of literature accumulated during the past year has been very carefully digested, and the latest knowledge and advancements incorporated. A practical feature of the work lies in the fact that nearly all the illustrations represent actual clinical subjects, showing the benefits of the X-rays at various stages of their application. The chapters by Caldwell give full details regarding the use and management of the apparatus, the text being fully illustrated with many photographs and drawings, including four full-page colored plates. The second edition has been brought strictly down to date, especially the case histories cited; and by the addition of much new matter and a number of new illustrations, the usefulness of the work has been greatly extended. It is the latest and best book on this subject.

## *Selections.*

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ADRENALIN.—In the *Therapeutic Gazette* for October, Homer Dupuy reports several cases in which the internal use of adrenalin for the control of hemorrhage gave most satisfactory results. In epistaxis the effects were very pronounced, and he calls attention to the (1) large and frequent dosage given — twenty drops of the adrenalin solution (1 to 1000) every hour or two for the first twelve hours; (2) the absence of any toxic or untoward effects; (3) the absolute control of the hemorrhage. In hemoptysis he has used it with very best results in fifteen to twenty drop doses per os, every three hours or so. In hemorrhage following tracheotomy, two hypodermic injections of fifteen minims of the 1 to 1000 solution in the space of ten minutes gave prompt relief. He suggests a gradual reduction of the doses and prolongs the intervals of administration to avoid the bleeding that might recur on the return of the vessels suddenly to their normal calibre.—*Cleveland Medical Journal*.

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THE FUMIGATION OF PUBLIC BUILDINGS.—The suggestion offered by Health Commissioner Darlington, of New York, of fumigating churches, theaters, and all buildings used for public gatherings, immediately after their use, is an excellent one. The majority of colds are contracted not so much from the much dreaded draughts of cold air as from the intimate contact of some one suffering from a coryza. Theaters and churches are, as a rule, notorious for their inadequate system of ventilation. To enter one of them from the pure outside air about the middle of the season is to be struck at once with the foulness of the atmosphere. That this foul air is the cause of the majority of colds, influenzas, and other air-borne diseases there is no doubt. In the interest of public health, ordinances should be passed compelling theater managers to at least thoroughly air their houses after each performance, and at stated intervals, say once a week, to thoroughly disinfect them with formaldehyde.—*Medical Age*.

THE WOMAN'S PERIL; THE MAN'S SIN.—In these progressive days, when medical science has worked out so many knotty problems, found a panacea for so many of the ills of life, that the one of most vital importance, and which has caused and is causing more disease and suffering than any, yes, all others together, should so long remain unnoticed and unchecked, is most surprising. I mean the so-called "social evil." The movement of the twentieth century is upon us, and it is a move of self-control.

To whom should parents and children go for advice as to sanitary and physiological conditions necessary to insure health and happiness, if not to the physician ?

It is very evident that perfect manhood or womanhood can not be reached through gratification of lust any more than perfect digestion can be secured by the same processes.

The doctrine that self-control is not necessary or possible with the male human being is the one that has brought about present conditions. The medical profession should lead in this oncoming social lift, or it will lose much that should belong to it.

There is no question of such vital importance to home and country, and no disease so fraught with evil and death as those resulting from these excesses; and all, or much at least, because of no proper teaching in the matter. There should be in every normal human being brain power sufficient to make them capable of self-control. When statistics tell us that 90 per cent. of all men are at some time sufferers from gonorrheal affections, we can but see that only 10 per cent. of men are physiologically well-developed beings, for normal healthy conditions do not beget disease. Add to this picture the entail that must result and we have a picture that would appall the world if spread out before it, which it will be, for the public are becoming aware that there is a great wrong somewhere.

Are the following conditions necessary evils? There are 300,000 women in our country leading lives of shame in houses of ill-fame, and one-half million candidates for this disease. Though the average life of these women is only five years, it is that much too long for the ruin they cause. No war was ever so devastating in its ravages. Out of 58,000 blind children in our large

cities, 15,000 innocent children are blind from gonorrheal ophthalmia alone. Other statistics, no less appalling, can not be given here; but can be found by referring to the *American Journal of Obstetrics and Diseases of Children* for February.

Medical science has studied the removal of the disease without reaching out to the cause, and have failed.

Women are becoming aroused as to the sudden death or invalidism of so many young, innocent women so soon after marriage, and are inquiring into the cause.

Dr. Joseph Price says: "There are more and better reasons for locking up in jail a man with gonorrhea than a murderer, and yet they are secreted by the thousands and go on in their murderous work of infection. Can we not remove from our midst, or reduce at least, many of our most malignant diseases by preventing this culture ground from becoming a predisposing cause?"

How much longer shall we hold our position as a proud American people, with this incubus clinging to 90 per cent. of our male population?

An eminent divine has said recently, "A man has no more right to poison his child with a loathsome, an incurable disease, than he has to poison it with noxious drugs." Though self-control may never have been a quality listed in his studies or his actions in the past, it is to be hoped the time is not far distant when it may be made a necessary requirement. — *Dr. Josephine Kingsley, in Texas Medical Journal.*

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ARGYROL seems to be replacing silver nitrate and the older astringents in the treatment of gastric ulcer, gastro-enteritis, typhoid fever, dysentery, etc. Argyrol, taken internally, is absolutely non-toxic, is not absorbed, and is unchanged, chemically, in the stomach or intestines; hence, with argyrol, it is possible to secure the local effects of silver directly upon the affected portions of the gastro-intestinal mucous membrane. The best method of administering it internally is 5 to 10 grains in capsules, followed by a glass of water, three times daily. It should never be dissolved in anything but water for use in the eye and urethra; other vehicles (such as glycerine) produce irritation.— *Ex.*

AT A RECENT Chamber of Commerce dinner the following story was told: "At the time of King Edward's recovery from appendicitis, thanksgiving services were held all over the British dominions. The services were concluded at a certain place by the singing of a well-known hymn that happened to be in the back part of the book. "Let us close the services," the rector said, "by singing the hymn, 'Peace, Perfect Peace,'—in the appendix."—*Ex.*

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PENETRATING WOUNDS OF THE ABDOMEN.—M. L. Harris (*Annals of Surgery*, March), discusses this subject, and cites a number of cases, concluding as follows:

1. In penetrating wounds of the abdomen, there are absolutely no known symptoms which indicate injury to any of the viscera, except those in connection with the urinary tract, stomach, and occasionally the lower bowel.

2. Except those relating to general shock, all symptoms following such wounds indicate either internal hemorrhage or peritonitis.

3. To wait for symptoms of perforation of the intestine means to wait until peritonitis has developed, therefore,

4. Every bullet or stab wound which penetrates the abdominal cavity should be operated on at the earliest possible moment in order to anticipate the advent of peritonitis.

5. No time should be wasted in attempting to demonstrate the presence or absence of intestinal perforation by such means as the rectal insufflation of gases or vapors, or the analysis of relected intraperitoneally injected air or liquids.

6. It is essential to systematically examine the entire gastrointestinal canal in all cases, regardless of the point of entrance of the wounding body.

7. Whenever the alimentary canal has been perforated, suitable drains (the author prefers the so-called cigarette drains) should be placed either through the operative incisions or counter-incisions, as may appear best suited to the individual case.

# **LISTERINE**

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—in—

## **SUMMER COMPLAINT**

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The absolute safety of Listerine, its well defined antiseptic power, and the readiness with which it lends itself to combination with other indicated remedies, are properties which have led many physicians to adopt Listerine as the antiseptic foundation of their prescriptions for Summer Complaint.

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A 32-page pamphlet on this subject containing many valuable suggestions for treatment, may be had on application.

**Summer Complaints**  
— of —  
**Infants and Children**



**Lambert Pharmacal Co., St. Louis**

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## Prescriptions and Formulary.

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### MYALGIA.

℞. Chloroformi..... fl. ʒij  
Linimenti belladonnæ..... fl. ʒiij

M. Sig.: (Poison.) Apply to the affected area with friction.

Indication.—Used in acute cases.—*I. J.*

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### CHAFING.

Dr. R. B. Elderic recommends the following in treatment of chafing under the arms and in the groins of infants:—

℞. Ichthyol.  
Tinct. benzoini comp  
Acidi borici aa..... ʒj  
Petrolati..... ʒiij

M. Sig.: Apply frequently through the day.—*Journal American Medical Association.*





# One Hundred for \$1.00 Have you tried **NAPHEY'S WAFERS?**

They are unsurpassed as a positive and speedy cure for Diseases of Women. They have been successfully prescribed by Physicians for ten years. We have increased the size of boxes from 25 to 100, which we are selling at the same price, \$1.00 per box, which puts them in the reach of every Physician for office use. Send for samples and literature.

**NAPHEY & CO.** - - - - - **Warren, Pa.**

## VOMITING OF PREGNANCY.

Crowley recommends the following:—

℞. Bismuthi salicylatis  
 Cerii oxalatis, aa..... ℥i  
 Mentholi..... gr. x  
 Cocain muriatis..... gr. iii  
 Spts. vini rect..... ℥i  
 Elix. aurantii, q. s. ad..... ℥vi

M. Sig.: Teaspoonful every three to four hours.

The following has also been recommended:—

℞. Sodii bromidi..... ℥iv  
 Elix. lactopepsin..... ℥ii

M. Sig.: Teaspoonful every three to four hours.

## GONORRHOEA.

℞. Hydrargyi chloridi corrosivi..... gr. ss  
 Aq. hydrogenii dioxidi..... fl. ℥j  
 Aq. dest..... fl. ℥xvj

M. Sig.: Use as injection.

Indications.—Chronic gonorrhœa or gleet.—*Ex.*

## BURNS AND SCALDS.

℞. Cocainæ..... gr. xv  
 Glyceriti boroglycerini..... fl. ℥iv

M. Sig.: Apply locally.

Indication.—Used to relieve pain.—*Ex.*

# SPECIAL OFFER TO PHYSICIANS WHO FURNISH THEIR OWN MEDICINES

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tificate), cut out this advertisement, attach the certificate and mail both to us and we will send you free of charge, one of these elegant Hypodermic Syringes which sell everywhere for \$2.50 each; this offer for one time only to each physician, afterward the certificate will be redeemed according to our regular plan. Write for our premium catalogue and see how we are able to make such elegant presents to our customers. If you can not get Bronchiline of your jobber, send us \$2.50 and this advertisement and we will ship you the Bronchiline and Hypodermic Syringe, you paying the Expressage.

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### SOME LAXATIVE MIXTURES.—G. F.

Little (*Brooklyn Medical Journal*) recommends the following palatable mixtures for the administration of castor oil and magnesium sulphate. He says that most children will take the following:—

℞ Ol. ricini,  
Glycerini, aa..... ℥j  
Ol. gaultheriæ, ..... m x

M. Sig.: A teaspoonful to a tablespoonful, according to age.

If called upon to exhibit the sulphate of magnesium, there is usually objection from a child, not to mention an adult. The very unpleasant taste may be fairly concealed by syrup of raspberry, as:—

℞. Magnesii sulphat..... ℥iv  
Syr. rubi idœi, q. s. ad..... ℥ij

M. Sig.: Tablespoonful or more at a dose. A tablespoonful contains one dram of Epsom salt.—*The Med. Standard*.

### ECZEMA.

Merck's *Archives* recommends the following formula:—

℞. Ichthyol..... ℥i  
Acidi salicyici..... gr. v  
Acidi borici  
Paraffin, aa..... gr. xx  
Petrolati..... ℥i

M. Sig.: Apply at bedtime.

The following has also been recommended:—

℞. Ichthyol..... gr. xv  
Zinci oxidi..... gr. xlv  
Acidi borici..... gr. xxx  
Petrolati..... ℥i

M. Sig.: Apply twice daily.



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### LEG ULCER.

R. Zinci oxidi..... 3x  
Gelatin..... 3v  
Glycerini..... 3j  
Aq. dest..... 3iiss

M. Sig.: Apply with a soft brush, changing the dressing every three to ten days.—*Medical Record*.

### AN APPLICATION IN PAINFUL METRITIS.

R. Camphor..... I gram  
Salol..... I gram  
Betul-ol (methyl-oleo-salicy. comp.) 2 grams  
Chloralhydrate..... 50 centigms.

M. et. ft. applic.

This is an antiseptic treatment which is easily applied on dilating the cervical cavity. Hot injections of one per cent. of huxsal are recommended to thoroughly cleanse the parts before this application.

### DROPSY.

R. Hydrargyri chloridi mitis..... gr. vj  
Pulv. digitalis  
Pulv. scillæ aa..... gr. xij

M. et ft. pil. No. xij. Sig.: One pill three times a day. Guard against ptyalism.

Indications.—Used in renal, cardiac, and hepatic dropsy.—*Ex.*

### CHRONIC LARYNGOTRACHITIS.

R. Formalin..... m xv  
Menthol..... 3ss  
Tinct. iodi..... 3ij  
Alcohol..... 3j

M. Sig.: Inhale four or five times daily.—*Ingals, Medical Record*.

### CARDIAC ADYNAMIA IN CHILDREN.

*Nouveaux Remèdes* recommends:—

R. Spartein sulphatis..... gr. iss  
Aquæ dest..... 3viss  
Syrupi aurantii..... 3vss

M. Sig.: For a child three years of age, two; five years, five; ten years, ten coffeespoonsful daily.—*Jour. Am. Med. Assoc.*

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EDITOR AND PROPRIETOR

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### *Original Communications.*

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#### STOMACH SURGERY AT THE MAYO CLINIC.

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BY WILLIAM D. HAGGARD, M. D., NASHVILLE, TENN.

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Over 600 operations upon the stomach and duodenum makes the operative experience of Drs. W. J. and C. H. Mayo, of Rochester, Minn., the largest in America. Something over 2600 operations a year, including all sorts of surgery, in their clinic at St. Mary's Hospital, presents the greatest number and widest variety of surgical work to be seen in any one clinic in the world. It has been my privilege to visit this clinic on three successive summers and it has occurred to me that a brief description of the methods of diagnosis and operations upon the stomach and duodenum would be of interest and, perhaps, of profit.

The surgery of the stomach has been the most recent and perhaps the most interesting problem in the evolution of the curative art. Recently chronic dyspepsia has been found to be

dependent upon gastric ulcer and its complications, such as pyloric obstruction. While fifty per cent. of the ulcers of the stomach are cured by medicinal and dietetic means, of the remaining fifty per cent., half of them die from perforation and hemorrhage, and the other half either drag along miserable lives as dyspeptics, with perhaps pyloric obstruction and dilated stomachs, to finally die of remote complications, such as degeneration of the ulcer into cancer, phthisis, or chronic anemia from prolonged starvation.

Unfortunately there has hitherto been no method of permanent cure for the hopelessly wretched sufferers. Some cannot be cured at all by medical means. It is impossible to say what proportion of chronic and obstinate dyspepsia is due to gastric ulcer; but Mayo says if that is eliminated, the cases of chronic dyspepsia, gastralgia, and cardialgia not due to gall-stones or the appendix, will be reduced to small proportions. It will be thus seen that the chronic stomach symptoms of a persistent and intractable form are most often due to some tangible pathologic cause if we will only seek closely enough for it, and that painful digestion is more frequently due to some mechanical interference with digestion and the proper emptying of the stomach than to mere supposed secretory errors and deficiencies. Knowing therefore these facts it only requires that we be, as Mayo puts it, "suspicious" of gastric ulcer in the inveterate forms of dyspepsia to finally arrive at a correct diagnosis.

How seldom is ulcer diagnosed in consideration of its real incidence, and how often do we summarily dismiss many stomach complaints with the diagnosis of "indigestion," or gastritis, and give them an acid or pepsin mixture, or the stomach tube. How many cases of appendicitis were overlooked in the past! Think of the cases of ectopic gestation that died without recognition fifteen or twenty years ago! Recall the many cases of "bilious colic" that in the light of our present knowledge would be easily recognized as gall-stones, without waiting for an obstructive jaundice to tell the tale; or what was more frequently the result, for the patient to go on for years with more or less pain and disability which might have been relieved by timely surgical interference!



Pneumogastric left

Ganglion

Pneumogastric  
right

Coronary artery

Coronary vein

Ganglion

Hepatic artery

Gastro-epiploic  
artery

Ganglion

Gastro-epiploic  
vein

PLATE I

FIG. 1. - Showing anatomy of the stomach with especial reference to distribution of the lymphatics.

*This, with the four succeeding plates, have been kindly furnished to this journal by the "Annals of Surgery," the greatest surgical journal in the world — ED. S. P.*



Mikolich-  
Hartmann  
inc

FIG. 2. — Showing ligation of *postero-hepatic* omentum and superior vessels in such manner as to leave all the lymph nodes attached to the part of the stomach to be excised ; also lines of division of duodenum and stomach.

#### PARTIAL GASTRECTOMY.

The difficulty about the recognition of ulcer and cancer in its early stages has been increased rather than simplified by the elaborate chemical and other tests which we have been led to believe are so essential to diagnosis, and so difficult of performance. The Mayos attribute only secondary importance to these tests, and they are employed only for the detection of the excess or the absence of hydrochloric acid, and the size and geography of the stomach. Of these tests 514 were made last year (1903) and of these 139 came to operation for lesions of the stomach and the first portion of the duodenum, which pathologically, clinically, and surgically is practically a part of the stomach.

The routine examination of the stomach cases, as practiced by Dr. Millet, at St. Mary's Hospital, is substantially the following: The patients present themselves at the Hospital at 9 A. M., fasting. A test meal of bread and tea is given and in an hour the stomach tube is introduced with the patient sitting, and a small quantity of the contents obtained by asking the patient to contract the abdominal walls, which expresses sufficient for a test for the absence or excess of hydrochloric acid by the Gunsberg, or more preferably, the di-methy-amido-azo-benzol test. A small quantity of this agent in solution will, when added to acid stomach contents, give a reddish color, which when there is an excess of HCL deepens with the degree of hyperacidity, and when HCL is absent makes a yellowish discoloration where the reagent drops. The more elaborate tests for quantitative analysis of HCL have not been found of great value and consume much time. While the excess of the hydrochloric acid is the classical concomitant of ulcer, and its absence indicates cancer, many exceptions are found to this rule, and the test, while confirmatory, should not be allowed to settle the diagnosis.

The stomach may be washed out if the presence of lactic acid or the contents indicate the fermentation and stagnation of retained food from pyloric ulcer. The presence of food in the stomach which was taken the day before is the most trustworthy sign of stenosis of the pylorus. To determine the presence or absence of dilatation, an ordinary Davidson syringe is attached to the stomach tube immediately after the test-meal is expressed, or after the stomach washing, and with the patient in the recum-

bent position and a towel to his mouth, the organ is inflated with air. A stethoscope applied to the epigastrium will detect the metallic sound of the valve in the bulb, transmitted by the air, in the stomach when the bell of the stethoscope is held over the stomach, and as soon as it is moved below the stomach the sound is lost. In this way the outlines of the stomach can be accurately determined and mapped out with a wet blue pencil. The air can be gently forced out when the experiment is finished.

These two simple tests comprise all that is necessary, and can be employed by every practitioner without elaborate apparatus and laboratory facilities. Broadly speaking, excess of HCL is indicative of ulcer, and dilatation of the stomach considerably below the umbilicus, if the lesser curvature retains its relation to the diaphragm, most often means an obstructed pylorus, caused most frequently by the contraction of a healed ulcer, or from a constricting or stenosing carcinoma. Three-fourths of the gastric ulcers occur in the pyloric region, and it is also the most frequent site for cancer.

The history of the case is given prime consideration in the Mayo examining room. The vomiting, hematemesis and melena, with local tenderness over the ulcer, and excess of HCL, comprise the rather pathognomonic symptom-complex of acute ulcer which is so often found in chlorotic girls, and when occurring in middle age, so often terminates life by perforation and hemorrhage. Acute ulcer in all cases, and especially in chlorotic girls, is not operated except for complications, hemorrhage, and perforation. Chronic ulceration is not so clear cut and easy of diagnosis.

The most conspicuous symptom is pain after eating. It is most often referred to as a burning pain, or of a boring character. There is more or less tenderness in the epigastrium, but the pressure points of acute ulcer are not so uniformly present. The Mayos attribute much importance to the pain occurring in "spells," being off and on for days or weeks at a time, and succeeded by periods of comparative health, lasting some weeks or months. Vomiting is rare unless there is obstruction. It is not wise to throw out chronic gastric ulcer because of the absence of hemorrhage. It is not often present, and even when it is present sufficiently to cause anemia, it may not be in appreciable quantity

FIG. 3.— Showing methods of excision. Note that all the glands on the greater curvature are removed in every case

#### PARTIAL GASTRECTOMY



FIG. 4.— Showing closure of cut duodenal end by circular suture and first row of sutures being placed on the stomach side.

**PARTIAL GASTRECTOMY.**

in vomitus or stool. Bloating is common and quite painful. Mayo believes this to be an important diagnostic sign which is rarely absent during the height of the pain. When pyloric obstruction is present, dilatation is the rule, retention and stagnation of food, late vomiting, sometimes of enormous quantities. The emaciation of this advanced form of starvation is very typical. The pallor of the attending anemia distinguishes it from the cachexia of cancer. The late cancer cases have the absence of HCL, and frequently a tumor. These clinicians think the early development of tumor is a fortunate circumstance for cancer victims, because it directs attention to the stomach by the obstruction and attendant symptoms which it occasions, and thus is more likely to be submitted to operation early, while there is still some hope of radical removal and permanent cure. Whereas carcinoma without tumor is not so easily and speedily diagnosed, and tends to go to its inevitable and inoperable doom.

It is strange why cancer of the stomach is still treated medically. They all die. Carcinoma in every other situation is quickly referred to the surgeon, and the permanent cure of carcinoma of the stomach in the future is regarded by Mayo to be equally as good as cancer of the breast. They have rarely had a patient who did not live longer than a year. One lived three years and seven months, and several are alive and well now after two years. Sixteen per cent. of the Mikulicz cases reached the five years period of immunity. This, too, should be possible with American operators and clinicians. Think of the possibilities it offers!

It is purely a diagnostic feat. Unfortunately many cases can not be diagnosed sufficiently early for a radical operation without exploratory incision. It therefore becomes a necessary aid to diagnosis and should be invoked by competent men often in view of the hopelessness by any other known treatment. It may seem heroic to perform an exploratory incision on merely the suspicion of cancer, and patients are supposed to object to it; but the Mayos find that when the matter is fully and frankly laid before the patient, that they rarely decline. Opposition to surgical diagnosis by exploratory incision oftenest comes from the profession, but when we reflect that we have no other positive

means of knowing, and that when all the text-books symptoms and laboratory tests are satisfied that the patient is beyond all hopes of succor, we should lend our insistence to the invocation of this the only dependable resource at our command. It is practically without mortality, and if the cancer is found inoperable from extension or fixation, the short incision can be quickly closed with buried sutures, and the patient allowed to get up and around in a few days, and leave the hospital within a week. But in reality the majority of exploratory incisions, which of course are early and suspected cases, will offer opportunity for the radical operation — pylorectomy (partial gastrectomy) — which the Mayos perform as follows:—

A median incision in the epigastrium of four inches gives room for thorough inspection and subsequent manipulation. Carcinoma-site is usually at the pyloric end or along the lesser curvature. The lymph glands run along it in the lesser omentum. The greater curvature is free of glands except at the right end. A section of the cancer-bearing area and glands is comprehended by division well through healthy duodenum and diagonally from left to right, beginning at a point on the lesser curvature a little way from the esophagus. The blood supply, consisting of the four large arteries, is secured by ligatures, and the greater omentum is tied off in sections and cut, thus mobilizing the pylorus. Double clamps are placed on the upper part of the duodenum, which is cut between. A continuous chromic catgut closes the cut end of the duodenum, which is invaginated by a sero-muscular purse-string-suture of Pagenstecher linen. The gastro-hepatic omentum is then tied in sections and severed. Two long Kocher stomach clamps are placed diagonally distal to the malignant induration at the place elected, and the stomach cut across between them by a cautery knife. The two margins of the gastric wall are clamped at intervals as the section progresses on both sides, to prevent retraction, and the cut edge of the small dome-shaped cardia to be left is sewed tightly with a lock-stitch of chromic catgut that is hemostatic and water-tight. The sero-muscular layer is then closed over the seam by one or two rows of a running Cushing suture of linen. A communication is then made between the smaller stomach pouch thus closed and



the alimentary canal by selecting a place on the jejunum about 14 to 18 inches from its beginning, turning a loop upon itself so the direction of its peristalsis will be the same as the stomach's, and making a gastro-jejunosomy by suture (the Murphy button can be used). An entero-anastomosis is then made with a button between the two limbs of jejunum which form the juncture with the opening in the stomach, and the proximal (left) limb, is obliterated by sutures which infold the wall into its lumen, both of which steps will be described later.

The operation is thus completely done from a carcinoma standpoint, and thoroughly done from a mechanical standpoint. These expert operators rarely consume over an hour in performing what may be regarded as the ranking operation in abdominal surgery. By this method they have had 19 cases in succession, with only one death; by previous methods, 22 per cent. mortality in about 40 cases.

If it is found that the cancer is inoperable from extensive glandular implication or forbidding adhesions, but is causing serious obstruction at the pylorus, life may be prolonged by short-circuiting the food into the jejunum, through a gastro-jejunal opening made with a Murphy button, or, as these operators prefer for cancer, the McGraw elastic ligature. On the anterior wall it does not disturb the tumor. It makes a large opening, and the time required by it to cut the opening through allows for extensive and safe serous approximation of the anastomosis.

In gastric ulcer, gastro-enterostomy gives rest to the grinding-like motion of the pylorus, and allows the ulcer to heal. Excision of the ulcer is only rarely resorted to, as the ulcers are often multiple, and one can never be sure, even with a speculum in the aperture of an incision into the stomach, that a small ulcer may not remain undetected. If the ulcer is healed and causes symptoms of pyloric blockage with consequent dilatation of the stomach, gastro-enterostomy finds its classical indication, and yields its most brilliant results. These surgeons have abandoned the attempt to enlarge the contracted pylorus by pyloroplasty. The ulcer may become active again, and in the badly dilated stomachs the compensatory hypertrophy and dilatation may become broken,

as in valvular insufficiency. Even if the pylorus be rendered amply patulous, the worn-out musculature can not lift the food bulk to the opening. Gastro-enterostomy at the bottom of the stomach drains it with ease and promptitude, and gives conspicuous relief to long sufferers. In selected cases the gastro-duodenostomy of Finney is the operation of choice.

They believe that the future operation for ulcer will be the excision of the ulcer-bearing area (pylorectomy), as suggested by Rodman. This is mechanically ideal, but the mortality is somewhat higher, and the gastro-enterostomy, as they perform it, seems to be well-nigh perfect. It is a composite operation that combines the best principles so far evolved in stomach surgery, and is planned to do away with any complications, either immediate or remote. In their large experience they have employed all the various technics. A large part of their knowledge of stomach and intestinal surgery was developed with the Murphy button, they having been the second to use it on the living subject. One objection to its use is its aptitude to drop back into the stomach and remain permanently. The suture, in practiced hands, can be used in nearly as short a time, and with much simplicity and safety. After using both the anterior (Wolfler) and posterior (Von Hacker) operations, Mayo established the surgical principle that the lowest point, whether front or back, should be chosen to avoid making an intra-gastric pouch, and that if that was done, it was immaterial which surface was chosen, and that there would be only an half inch difference in the two openings.

In the spring of 1903, Moynihan, and then Von Mikulicz, the greatest English and German authorities on stomach surgery, while in America, visited Rochester, and demonstrated their methods, both of which were subsequently employed in the clinic at St. Mary's. The Moynihan technique made use of the 9-inch jejunal loop, fastened posteriorly by linen suture. Mikulicz does the Czerny operation by uniting the jejunum transversely, about three inches from its origin, at the duodeno-jejunal junction, and as it lies behind and immediately in contact with the site of anastomosis with the stomach, the meso-colon alone intervening. I have described that operation in detail elsewhere. It seemed

FIG. 5.— Showing completed operation.

PARTIAL GASTRECTOMY.

Gastro-Enterostomy. The stomach (above) and jejunum (below) held by clamps. They are sewn together behind by two rows of sutures seen through enclosed aperture. The inner of the two rows is being continued to make the anastomotic circle. It will be reinforced with a second row when completed. (Orig W. D. H.)

ideal, but if any trouble arose at the site of anastomosis, so the biliary and pancreatic juices did not pass by that point readily, there was no proximal jejunum left to make an entero-anastomosis to carry down these important secretions. While it did not give any immediate flow of bile into the stomach or vicious circle (which with badly-planned gastro-enterostomies is so troublesome and often fatal), yet some of the cases had discomfort afterwards from small amounts of bile getting into the stomach, not enough to cause violent vomiting, but to produce nausea and uneasiness. Moreover, the opening must be of limited size. Hence the Mayos wished to go back to the longer loop to obviate this occasional failure to give perfect relief, and to have a longer limb of jejunum, they make an entero-anastomosis, which they now do primarily, and also to secure an opening of at least two and one-half inches inside measurement.

The probabilities of immediate vicious circle or remote regurgitation of small amounts of bile into the stomach, is obviated by closure of the proximal limb of the loop between the stomach opening and the lower union of the two limbs of the jejunum.

The method in detail, now employed, is as follows: Incision to the right of the mesial, through the rectus muscle. The gall-bladder is examined. The ulcer, whether stomachal or duodenal, is usually recognized by a thickened area over which the peritoneum is adherent and whitish. Indurated glands near it in the omentum may act as "sentinels" to indicate its proximity. The posterior wall of the stomach is reached by holding the transverse meso-colon up and bluntly opening it at a point devoid of blood vessels of consequence, taking care not to wound the middle colic, which injury has been known to cause death of a large part of the colon. The stomach wall is brought through this aperture and a relatively bloodless point selected about the middle of its greater curvature and near the bottom. A three and one-half inch fold is grasped by a Doyen forceps padded by rubber tubing, and a similar longitudinal fold of jejunum lying adjacent and nine inches from its origin, is held outside of the abdomen in another forceps, alongside the stomach forceps. The viscera are carefully returned to the abdomen and protected by copious gauze barricades. The two portions of viscera to be anastomosed are

sewn together for a distance of two and one-half inches by a continuous linen thread, after the method of Moynihan, which will constitute the outermost and under layer of the posterior half of the anastomotic circle. After transversing this distance, the needle and thread are rolled in gauze until the viscera are opened and the circle completed by the innermost suture. The temporarily discontinued suture is then resumed to complete the top layer or outermost suture circle.

The serous and muscular layers are incised parallel to each other one-fourth inch above the first or back suture; the redundant mucosa in the ellipse of each incision is opened and trimmed away. The inner (adjacent) cut margins of both viscera are now sewn together by a continuous chromic cat-gut suture. This goes through all three coats of both cut edges, and constitutes the inner layer of the posterior segment of the anastomotic circle. It is continued around the cut margins, bringing them together as it goes, making the completed circle of the two viscera. It is a hemostatic suture. The outer half of the circle is brought together by a stitch devised by Dr. C. H. Mayo. It enters the peritoneal surface and emerges through the mucosa, makes a loop in the lumen and enters on the mucous surface again and emerges through the peritoneal. It then enters upon the peritoneal surface of the opposite edge, out through the mucous, and back again from mucous through to serous, and when drawn taut and continued, turns the peritoneum in all the time and buries itself inside the lumen. It might be called a continuous, inside, mattress suture placed from the outside. It was suggested to them by the Cornell suture, which was placed from the outside.

After the first or back row of sutures are introduced and while the viscera are still open, half of a medium sized Murphy button is introduced into each limb of the jejunal loop, and at a point previously marked on each, about four or five inches from the suture anastomosis, the button shanks are pushed through small nicks over their lumens and clasped together, making the entero-anastomosis for certain deflection of the biliary and pancreatic juices; and to absolutely prevent their peristaltic propulsion past the entero-anastomosis and into the stomach, the ascending limb of the loop is obliterated by the method of Mattoli: three or four

interrupted sutures of linen, catch points on the sides of the jejunum midway between the mesentery and the center of the convexity opposite the mesentery and catch similar points on the other side. When drawn together this troughs the upper wall into the bottom of the jejunum, and by closing the sides together effectually obliterates its lumen without strangulation.

Throughout all these maneuvers careful attention is paid to keeping the field of operation isolated from the cavity and viscera, by generous and well-arranged gauze pads. The patients are propped up on pillows when put to bed and immediately after are given water and liquid nourishment early.

There have been twenty-six operations by this particular method, with no deaths. There has been but one death in a series of eighty-six unselected stomach cases of all sorts since March 1, 1904, and this death occurred after a gastero-enterostomy of a man eighty years of age.

Morphia is administered before the anæsthesia to minimize the amount. The visceral suturing is not painful, and practically little or no anæsthetic is given after narcosis is complete. Ether is commonly used by the Prince, or drop method. The two anæsthetists each give over a hundred a month, and nowhere else is anæsthesia so perfected. Miss Alice Magaw has given over 12,000 administrations.

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## HIP-JOINT AMPUTATION—WITH REPORT OF CASES.\*

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BY PAUL F. EVE, M. D., NASHVILLE, TENN.

---

As we look over the literature of this formidable operation, we find that Morand was the first one to suggest it in the year 1739: and in 1743 Ravaton proposed to operate by the removal of the hip joint, for a gun-shot wound of the thigh, but was overruled by his colleagues. The first operation therefore that was performed, was by La Croix d'Orleans in the year 1748, the subject being a fourteen year old boy, both thighs of whom were gangrenous (the result of eating diseased rye). The right

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\* Read at Meeting of Nashville Academy of Medicine, June 28, 1904.

hip was first amputated, and four days after the left hip was operated upon. The patient survived eleven days after the second operation.

The first successful operation was performed by Perrault of St. Maure, in Touraine, in the year 1773, the subject being a man, who had gangrene of the thigh nearly to a line with the pelvis, the result of a crushed wound received between the pole of a carriage and a wall.

The first reported case in England occurred in 1774, the operation being performed by Mr. Kerr of Northampton, the subject being a young girl twelve years old, suffering from abscess of the right hip and involving the acetabulum; the patient surviving the operation 11 days. The first successful hip-joint amputation in America occurred in the year 1846, and in the hands of Dr. Walter Brashear of Bardstown, Ky., and as our modern operation is planned somewhat after his type, I shall give the steps of the operation as written by himself.

“ The subject was a boy seventeen years of age. Without assigning the causes which led to the necessity of the operation, the same was, after consultation with Drs. Harrison and Goodlett, conducted in the manner following: First, premising that in absence of any knowledge of an established mode for his operation a common sense reasoning as to its safety and facility alone dictated the manner of performing it. Therefore, an operation on the thigh in the ordinary manner was determined upon, as remote from the hip-joint as circumstances might justify (in this case about mid-thigh). The amputation was performed and the arteries secured. The next step was to make an incision to and from the lower end of the bone externally over the great trochanter to the head of the bone and upper part of the socket. The dissection of the bone from the surrounding muscles was simple and safe, by keeping the edge of the knife resting against it. The bone disengaged from its integuments at its lower extremity, was then turned out at a right angle from the body, so as to give every facility in the operation to separate the capsular ligament and remove the head from its socket. After the operation nothing more than ordinary dressings were used, and



in the course of a short time the patient removed to St. Louis, where he was living within a few years past."

From these early operations we proceed to the methods employed forty years ago, and to the methods which we now employ. First, the single antero-internal flap method, as preferred by Langenbeck, Guerin, and Malgaigne. This method being the one in vogue during the war between the States. Supposing it to be the right hip, the patient is placed upon his back, the nates resting upon the lower end of the operating table. The thigh is slightly elevated and adducted, so that the point of a long amputating knife can safely pass between the head of the bone and the vessels (previous to this incision a trouniquet is applied to the external iliac or abdominal aorta). The amputating knife being twelve to fourteen inches long is introduced at a point above and one inch in front of the trochanter major, the edge of the knife being directed downward in the line of the axis of the limb. With a slight sawing motion of the knife an incision downward is made sufficient for an assistant to introduce the four fingers of each hand and grasp the femoral vessels between his thumbs and fingers, and a flap of from five to seven inches in length is made. An assistant now grasps the knee and leg, rotating the thigh outwards, at the same time forcibly abducting and carrying it backward over the end of the table. By this means disarticulation is effected, the amputating knife is passed under the head of the bone, cutting the parts posterior to the articulation, the knife emerging in the gluteal fold — all the arteries are now secured and the flaps approximated. Es-march's method consists in operating in two steps. A circular thigh amputation six inches below the trochanter, followed by removal of the remaining portions of the femur by an external lateral incision. But by far the safest and best method for this formidable operation, which used to be considered unjustifiable, is the one devised by Wyeth, and known as Wyeth's bloodless method. The technic of this operation is briefly as follows: Two steel pins ten or twelve inches long, and about 1-5 inch thick are introduced for the purpose of holding a tourniquet above the hip-joint. One pin is placed one fourth of an inch below the anterior superior spine of the ilium, and slightly to the

inside of the prominence and is made to traverse superficially for about three inches the muscles and fasciæ on the other side of the hip, emerging on a level with the point of entrance. The second pin is pushed through the skin and tendon of origin of the adductor longus muscle, one half an inch below the crotch, the point emerging an inch below the tuber ischii. The points of these pins are secured by corks and the tourniquet tightly tied above them. If the case is admissable, an Esmarch bandage is used upon the limb and all blood driven into the body. If this bandage has been used, it should be removed after having secured the tourniquet. A circular incision is made in the skin of the thigh about six inches below the tourniquet, and a longitudinal incision in the line of the trochanter from this incision to the tourniquet. The integument is now dissected back, the soft parts divided down to the bone even with the lesser trochanter. The large vessels are tied at this point, and all muscular insertions separated from the trochanters and the upper part of the femur. The capsular ligament now being reached is cut through, the limb disarticulated and the ligamentum teres divided. After securing the sciatic, obturator, and descending branches of the external and internal circumflex arteries, the flaps are approximated and the wound dressed.

It has been my privilege to have operated upon six cases of hip-joint amputation, which I briefly describe as follows:—

My first case came under my observation in 1891. A negro about thirty-eight years old, who received a gun-shot wound of the thigh, producing a compound fracture of same. He was not brought to our city until about a week or ten days after the injury, and when seen by me, the wound presented two large sloughs upon the external and internal surfaces of the thigh. The negro was suffering with pyœmia and was treated some time for this affection. After a long convalescence, in which the disease of the bone attacked the hip joint, seeing that nothing but a hip-joint amputation promised relief, after consultation I performed this operation upon him after the method of Langenbeck; however, before making this amputation, I had by incision secured the femoral artery, just as it passed under Pou-

parts ligament. The patient made a tedious but complete recovery.

My second patient was a white boy ten years old, who came under my treatment in the year of 1893. His thigh was crushed under the wheel of a moving ice wagon. Mortification came on shortly after the injury, and spread rapidly to the hip joint. The operation was performed similar to the first one, the patient surviving the operation seven days.

My third case occurred in the same year. A white man, a tramp, who had both thighs crushed by car wheels running over them. He remained ten hours in the rain before being brought to the city. I treated him for some time for shock, and when reaction commenced to slowly set in, finding some hemorrhage which was not entirely controlled by the tourniquets which were used, after consultation, I amputated both hips, the patient surviving the operation sixty hours.

The fourth case occurred in 1901. A white boy, ten years old, with tuberculosis of the femur. I first attempted to save the limb at the upper third of the thigh, and an amputation was made at this point, but the disease advancing, I was compelled afterwards to amputate at the hip joint, also to chisel out some portion of the acetabulum. The patient made a slow but complete recovery.

The fifth case was a negro man twenty-three years old, family history negative, who received some time before the operation, which occurred in 1902, a fall, producing a fracture and dislocation of the hip (extra capsular). When I saw him he had several fistulous tracts leading to diseased bone, and while I expected only to resect the head of the femur, when I undertook this operation, and reached the bone, I found it in such a condition that after a hurried consultation, amputation at the hip joint was advised and performed. The patient made a very satisfactory recovery and is now in excellent health.

The sixth case occurred this year and in this month. A negro man, twenty-eight years old, family history tubercular. When admitted to the Hospital, he was suffering with a tubercular trouble of left knee. My intention was to operate upon the knee and either to drain the joint or at least to resect same.

When, however, I got down to the bones of the knee joint, I found them in such a condition that it was impossible for me to save the joint and an amputation of the thigh was made just above the knee. Finding that the bone at this point was so much diseased, and that the disease continued in the upper part of the thigh I was compelled to perform a hip-joint amputation. While this operation was performed only on the 13th day of this month, my patient is doing so nicely and making such a satisfactory recovery that I concluded to report this recent case. In conclusion, I will say that the last three cases were operated upon after the Wyeth plan.

A slight departure from Wyeth's method was pursued in the last operation, which was caused by my not being able to procure at the time the long pins. A tourniquet was placed upon the thigh as high as it was possible, and a circular incision of the thigh was made six inches from the hip joint. A lateral incision was now made as far as the tourniquet, the parts dissected from the bone to the tourniquet and the superficial femoral and deep femoral vessels ligated. I also found and ligated the gluteal. The tourniquet was now loosened and all bleeding points grasped by hemostats. The tourniquet now being removed, the lateral incision was extended as in the Wyeth method, the hip disarticulated and all vessels secured. During this operation but little blood was lost. Since the report of this case before the Academy of Medicine (Aug. 15, 1904), my patient has made a complete recovery and is going everywhere on crutches.

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### POST-PARTUM HEMORRHAGE.\*

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BY J. T. ALTMAN, M. D., NASHVILLE, TENN.

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We mean by this, hemorrhage coming from any part of the parturiant canal after the expulsion of the child. This hemorrhage may be from the placental site, or cervix, vagina, perineum, or clitoris. The most serious form is when it comes from the placental site, and it is to this variety alone that we will confine

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\*Read at Meeting of Nashville Academy of Medicine, Aug. 31, 1904.

this paper. The hemorrhage is primary when it appears within the first twelve hours after delivery, and secondary at any later period. Primary hemorrhage rarely appears after the first two or three hours. It may be open or concealed, but is most usually open, although the concealed form is more dangerous. A woman may actually bleed to death with no noticeable blood externally. As to the amount of blood lost after labor, which constitutes post-partum hemorrhage, I might say it varies very materially in different women.

The average loss sustained is one pint, though many women lose as much as one quart without producing any deleterious symptoms. The quantity of blood lost alone, is not our guide, but the effect upon the system in any given case.

The graver form of this condition is comparatively rare in the hands of careful and competent obstetricians. Most of the severe types occur in the hands of the careless doctor and especially in the hands of the ignorant midwife. More than once have I been called by the old midwife just in time to prevent an untimely death from hemorrhage. It occurs, in all of its forms, in nearly five per cent. of all cases, in the hands of an expert like Edgar. It must occur more than twice that often in the practice of the ordinary practitioner and the ignorant midwife. The proportion of the different types, according to Edgar, is as follows: the mild form unattended by marked symptoms, once in fifty cases; the very severe, once in one thousand cases; and fatal, once in five thousand cases.

I have never seen a fatal case, but the severe forms have been as frequent as one in four hundred cases, my work being almost entirely private and much of it in unfavorable surroundings. It may come on almost immediately after the completion of the second stage, before the placenta is expressed or afterwards. It occurs more than twice as frequent after the placenta is expelled. We may think that a condition that only occurs in five per cent. of all cases is not of very great moment, but we should remember that this ratio is in the hands of an expert, nearly two thirds of which are in a well regulated hospital with the best equipment for proper management. Its frequency must necessarily be much

increased in the hands of the unskilled physician and the ignorant midwife.

While the direct mortality may not be so high, the resulting morbidity is very important. The conservatism of nature is better illustrated in protecting the parturiant woman from fatal hemorrhage than any other condition we have to encounter. Nature provides against this fearful catastrophe in three ways; viz., changes in the blood vessels of the uterus, changes in the size and arrangements of the uterine musculature, and changes in the blood itself. The blood vessels are enlarged, but become thinned out, thus increasing their contractility, the muscular fibres so arranged as to compress the mouths of the torn vessels, and the fibrinogen is markedly increased, which favors the coagulation of the blood in the torn sinuses. When any or all of these factors are interfered with the danger is great, and the woman's life is placed in great danger.

*Etiology.*—As predisposing causes we will mention certain blood changes, as albuminuria, leucocythemia, alcoholism, and malarial toxemia. Hemophilia, fortunately rare, is an extremely dangerous condition. Ahlfield reports a case where the woman bled to death with the uterus well contracted, and no lacerations at all. The blood would not coagulate, and the tampon failed to stop the hemorrhage. Certain conditions of the liver, heart, or lungs, which either cause marked changes in the blood or interfere with the return current, may also predispose to it. It occurs more than twice as often in multipara as in primipara, and especially in those who have children rapidly, on account of the relaxed deteriorated muscle fibers. The constitutionally weak and delicate woman, and those in the higher walks of life, are more susceptible than those who have to take more outdoor exercise. Previous hard labors, long protracted, tedious labors, and all cases of over distension, as in the case of twins, and hydramnios; a weakened musculature, such as occurs in fibroids and a bicornate uterus; precipitate labors, where the uterus is suddenly emptied, are very apt to lead to inertia; also the rapid extraction of the aftercoming head in breech cases that have been long and tedious. Over-distension of the bladder or rectum, and the long continued or injudicious use of chloroform, strongly predispose

to uterine inertia. I think the most important exciting cause is the improper management of the third stage of labor. This applies particularly to the too early and improper resort to Crede's method of expressing the placenta, and pulling on the cord before the tired uterus has had time to rest from the severe work it has just gone through.

*Symptoms:* I will not take up your time to-night in giving the symptoms in detail, as they are so pronounced that they could scarcely be overlooked. If the hemorrhage is external, the blood passes in continuous torrents, as it were, in severe cases, while in the milder type it is intermittent, large clots being thrown off at each uterine contraction. The concealed variety is the one that is liable to be mistaken for other conditions. Here we have the cardinal symptoms of shock that supervene very rapidly, which is confirmed by palpating the abdomen. The uterine tumor is not felt, and the abdomen is very large. This may be mistaken for syncope, which may occasionally come on after rapid labors, and after twins or hydramnios. This is due to the sudden cerebral anemia caused by the sudden withdrawal of the abdominal pressure. This is quickly relieved by lowering the head and applying an abdominal binder tightly and firmly. We may mistake it for the abdominal enlargement that is sometimes found on account of gaseous distension of the bowels. This may be quickly eliminated by percussion, palpation, and vaginal touch. Hysteria may confuse the unsuspecting, but is easily differentiated by the physical signs. The external variety may be mistaken for rupture of the uterus, or for lacerations in the cervix, vagina, perineum, or clitoris. The symptoms in rupture of the uterus comes on in the second stage, labor ceases, and the fetus escapes in the abdominal cavity. If the bleeding comes from lacerations, the uterus is contracted, the blood is a bright red and is continuous, but not so rapid or severe.

Olshousen describes a dangerous kind of hemorrhage which is due to paralysis of the placental site when the rest of the organ is contracted. I have never encountered this condition. The prognosis of post-partum hemorrhage depends upon many different factors. The earlier it begins after the expulsion of the child the graver it is. The concealed is more dangerous than the



open because it is longer overlooked. If the blood is serous and will not coagulate, as in hemophilia, it is nearly always fatal. It also depends very largely upon the general condition of the patient before labor, and the competency of the physician to carry out the prophylactic measures.

*Treatment:* I desire to first call particular attention to the prophylactic treatment, which is very important indeed. If proper precautionary measures are taken in all cases, the severe forms of this condition will be very rare indeed. Some few cases will occur in the hands of the most careful obstetrician, but by far the greater number are caused by faulty management. The preventive treatment begins long before labor sets in at all. If she has albuminuria, leucocythemia, or alcoholism, she should receive proper treatment before hand. The nervous, muscular and circulatory systems should be put in the best possible condition. If the woman is weak and worn out by overwork, insufficient food, or frequent child-bearing, she should have mental and physical rest, fresh air, and plenty of nutrition. Having corrected, as far as we can, the constitutional causes, we now come down to proper management during labor. If we suspect a precipitate labor, put her to bed early, restrain as much as possible all muscular exertion, rupture the membranes early, and administer chloroform. On the other hand, we should not allow a long, tedious labor to proceed until nature is exhausted. The bladder and rectum should have been emptied before the child is expelled, as they may cause uterine inertia. If the uterus and abdomen are over-distended, as in hydramnia and twins, we should watch closely. In every case of labor we should follow the fundus down as the child passes out and uterus is held by the obstetrician or an assistant, to see that it is not only contracted, but remains so. Don't knead or squeeze the uterus, but simply hold it firmly against the pubic bone. If it relaxes, resort to friction by rubbing, which will stimulate contraction better than forcible kneading. The hand should then be kept upon the fundus, and if there is no hemorrhage we should wait at least thirty minutes before we try to express the placenta, unless it becomes detached sooner, which is shown by the fundus rising up. A teaspoonful of Squibb's Fld. Ext. Ergot at close of second stage, or Ergone



hyperdermically, if inertia develops. If the uterus relaxes in spite of this management before the placenta is expelled, and hemorrhage takes place, our first effort is to empty the uterus at once. This should be accomplished by Crede's method, if possible. Never enter the uterus if it can be emptied by external manipulation. If this fails, then lose no time, because every second is valuable in a severe case, but at once pass the sterile hand up into the uterus, detach the placenta and membranes, grasp the uterus with other hand, and forcibly expel the hand, placenta, membranes, and all clots. In many cases this suffices. If still the uterus refuses to contract, or once contracted it again relaxes, we should at once reintroduce the hand well up into the uterus, close the fist, carry the back of the hand forward over the symphysis, at the same time the other hand forces the fundus down and forward, compressing the uterus between the hands, at the same time anteflexing it. This controls the hemorrhage absolutely, but is very tiresome to the physician. Holding it thus for several minutes, until an assistant can prepare some sterile hot water at a temperature of 115 or 120, to which is added a 2 per cent. solution of creolin, with the hand still in the uterus. the syringe is carried up to the fundus, and at least a gallon of this hot solution is allowed to flow. This will usually bring on uterine contraction sufficient to expel our hand, being careful to bring all clots with the hand. Plain sterile water at that temperature is efficient, but I prefer the creolin solution, as it is both stimulating and antiseptic. Some advocate vinegar or acetic acid, which is very efficient, but has two objections. It is extremely painful and is not aseptic. Ice in the uterus has been recommended, but I do not like it, as it is not clean, and may add to the subsequent shock. When I was a student, such astringents as the per chloride of iron in solution was highly recommended and extensively used. I only mention it now to condemn it. While it is effective it produces such a dirty coagula that it leaves a good field for infection. A solution of the suprarenal chloride is recommended, and I doubt not is effective, but I have had no personal experience with it.

If the manual means, combined with the hot creolin douche, will not cause a continuous contraction, I would not fool away

precious time by trying this or that, but resort at once to the measure that will control absolutely the hemorrhage, unless it be due to hemophilia, and it is the best thing to do then. I refer to packing the uterus with sterile gauze. To those who have not tried to do this it may appear an easy procedure. But in those cases where it is really needed it requires some tact. The usual method consists in grasping the sides of the cervix, pull it down to the vulva, and with curved dressing forceps pass the strips of sterile gauze into the uterus, taking particular pains to fill the fundus first, then the lower segment, then the cervix, and finally the vagina from the fornices to the vulva. The danger of this method is the great probability of carrying infection into the uterine cavity. I will show you a safer and easier method by means of this little instrument devised by Holmes, of Chicago, which I will pass around for inspection. With this instrument at hand and sterile, and a jar of gauze strip three inches wide and fifteen yards long, tightly packed in a glass jar, sterilized by dry heat, and an air-tight top applied and never opened until ready to use. With this instrument and the gauze thus prepared and always in our obstetric bag, we can easily pack the uterus at a minimum risk of infecting our patient. This requires no assistant, except some one to hold the jar and make pressure upon the fundus above. After thus packing the uterus and vagina, a vulva pad is applied, held in place by a T bandage tightly applied around the abdomen. In twelve hours this should be removed, the uterus washed out with the hot creolin solution, when the uterus will contract down, the sinuses will be closed by coagula, and there will be no further hemorrhage. As soon as the hemorrhage has been controlled we must now combat the resulting shock. During the shock following the loss of blood the patient is extremely restless, tossing about to and fro. I know of nothing so effective as a hypodermic of morphia and atrophina and strychnia. At the same time, or preceding this, resort to hypodermoclysis, and put a quart of the normal saline in the rectum also. Lower the head, raise the foot of the bed, and bandage the extremities to throw all the blood possible to the brain to relieve the anemia. Stimulants should be used with care, as they tend to produce a cramp of the heart under these circumstances. After the immediate

shock is over we then give concentrated nourishment, iron, arsenic, hypophosphites, cod liver oil, etc. Shut out all visitors, and keep the patient absolutely quiet in the recumbent position for several days. Rectal salines should be kept up at intervals for two or three days to supply the demand for water. Thus treated the woman usually makes a rapid and satisfactory recovery.

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### SEPTICEMIA.

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BY A. C. MUTTART, M. D., NEW YORK CITY.

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Believing that the following cases will be of interest to you, as well as to the medical profession — to you, because it proves the value of your preparation; to the physician, because it shows that our text-books sometimes err, and because cases of this kind and at this stage are usually considered hopeless — I beg to submit the following report:—

On June, 21, 190-, I was called to see a lady who, according to the prognosis of her attending physician, could not live twenty-four hours. A subjective examination elicited the following history: Mrs. J. H., age twenty-six, multipara. Previous health especially good. On June 5 she had been delivered of a still-born, full term, third child. For two weeks following she had experienced considerable pain through the pelvic region with two slight hemorrhages accompanied by very offensive lochia. On the 15th she had a slight chill followed by a decided rise of temperature which had continued until, and was present at the time I was called. Objective examination showed a temperature of 106 1-5° F. Pulse 158, very irregular; respiration jerky; tongue slightly coated; marked distension of the abdomen, and bowels constipated, no movement having occurred for several days.

It was a very clear case of septicemia, and if anything was to be done it must be done at once. Strychnine Sulph. gr. 1-30 was administered hypodermically, and after cleansing out the rectum and lower bowel, gave Spts. Frumenti and Ammonia per enema. The patient was then rendered as aseptic as possible, and being anæsthetized (ether being the agent used), was placed in the dorsal position with hips drawn well to the side of the table and

thighs flexed and held. After a hasty digital examination, placental forceps were introduced and with the assistance of the middle and index finger succeeded in removing about one third of a decomposed placenta.

Owing to the lateness of the hour all drug stores were closed and the only antiseptic I happened to have about my office was a bottle of Glyco-Thymoline. This being considered as better than nothing, was taken along; also some Saponi Viridi. After removal of placenta, the entire endometrium was gone over thoroughly and carefully with a sharp curette. The uterine cavity was then irrigated with Glyco-Thymoline pure, and loosely packed with gauze soaked in the same solution, as well also the vagina, my object being to obtain its exosmotic effect as well as contraction of the uterine walls. Post-operative saline enema was given at 4 A. M., and cardiac stimulants reduced. Temperature at 8 P. M. was 103 2-5° F.

January 22, 8 A. M., temperature 102° and at 8 P. M., 101° Dressing removed and directed that vaginal douches of Creolin, one per cent., be given every four hours.

January 23, 8 A. M., temperature 102°. Uterine dressing forceps well wrapped in gauze were passed over the endometrium to remove any clots of blood that might have been retained, and uterine irrigation with a 1-5000 solution of bichloride of mercury followed with 95% alcohol and then packed with gauze soaked in the alcohol solution, *i. e.*, "Practical Obstetrics," third edition. Temperature at 8 P. M., 103 3-5° F.

January 24, temperature 8 A. M., 103 4-5° F. Dressing removed and uterus irrigated with pure Glyco-Thymoline and packed with gauze soaked in same as on first occasion. 8 P. M., temperature 102° F.

January 25, 8 A. M., temperature 101 3-5°; 8 P. M., 100 3-5°. Dressing removed and again irrigated and packed with Glyco-Thymoline and gauze.

January 26, 8 A. M., temperature 99 4-5°; 8 P. M., 99 2-5°.

January 27, 8 A. M., temperature 99 1-5°. Dressing removed and irrigation with Glyco-Thymoline only. 8 P. M., temperature 99°.

January 28, temperature normal and remained so. Irrigation

continued in conjunction with tampons of Glyco-Thymoline and Ichthyol for two weeks.

Fifteen months later the patient was delivered by me of a full term, eleven pound child and enjoyed a rapid convalescence.

Since then I have employed Glyco-Thymoline as an intra-uterine application in a great many cases and cannot recall one instance where it failed to prove most satisfactory.

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## *Abstracts.*

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### SUBLAMINE AS A HAND DISINFECTANT.

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BY PROF. B. KROENIG, OF JENA.

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*Abstracted from the Monatsschrift für Geburtshilfe & Gynäkologie, No. 1, 1904.*

I desire herewith to correct some mistaken conclusions drawn by Dr. Schaeffer (Vol. I, No. 3, of this publication) from the experiments made with Sublamine by Blumberg and me. On the basis of very thorough bacteriological examinations this drug has been praised very highly indeed by Paul, Sarvey, Fürbringer, Fueth, Engels and many others, and it has been employed for years with most excellent results in the Leipsic, Jena, and other clinics.

Shaeffer is in error when he claims that all comparative experiments with hand disinfection, to be decisive, must be done on the hands of the same subject. Such tests would be fallacious, as each disinfection would lessen the receptiveness of the hand for bacteria; and if we were to wait a few days each time in order to allow the effects of the last disinfection to disappear, it would be impossible to employ bacteria of equal resistance for each test. The liability of error is far less when different hands are infected with a medium of nearly the same virulence on the same day. I have made due allowance for every possible source of error in these tests, and have always emphasized that my results are not of absolute, but only of comparative conclusiveness.

Schaeffer also thinks that it would be better to test concentrated solutions of antiseptics on pure bacterial cultures. But this method would lead to false conclusions. Paul and I at first used it, trying over 100 antiseptics in pure solution. But when we tested them in the presence of organic substances, especially upon the skin, we recognized that their action there is entirely different. For instance, chlorine water is the most powerful antiseptic in its action on spores and vegetative forms, as is also chlorine gas as developed in a watery solution of potassium permanganate and hydrochloric acid. Even solutions of 1 per cent. of the potash and  $\frac{1}{2}$  per cent. of the acid were extremely effective. But when this solution was tried on the properly prepared skin, there was no such intense bactericide effect to be seen. For not only spores, but vegetative forms of the bacteria could be gotten from hands so treated, even when the antiseptic was allowed to act for many minutes. Chlorine loses almost all its efficacy in the presence of organic substances. A 1:1000 Sublimine solution, whose action is not to be compared with that of chlorine water on pure bacterial cultures, has a much more intense bactericide energy on the skin. This shows that we can draw no conclusion as to the action of disinfectants on the skin by their effect on pure bacterial cultures.

When dealing with solutions containing organic combinations, a direct bactericide action is far less necessary than inhibitory effect on bacterial growth. For if we succeed in impregnating the skin with a disinfectant which continues to exhibit an inhibitory action when particles of the skin are transferred into an animal body, we have attained the desired object,—namely, to disinfect the skin so that it can no longer infect. Hence we do not need to employ those metallic salts which are most actively inimical to pure cultures; there may be others which are better, either because of superior penetration or other practical advantages.

Schaeffer further objects to the animal experiment as a means of testing the efficacy of disinfection. The manifold difficulties connected with it, and the various possible sources of error, we have stated in our various reports. But Schaeffer mistakes in preferring his method, namely, subsequent culture of the skin scrapings on artificial media as a means of determining whether

the bacteria have been killed. Disinfection is not necessarily synonymous with destruction of all bacteria. By disinfection we mean that the antiseptic employed has so reduced the virulence of the bacteria that they are no longer capable of growth and multiplication on a given medium under a certain temperature; but it by no means follows that the bacteria have been absolutely killed, and it is readily possible that under favorable conditions, perhaps in the body, they may again develop. The culture test is especially unsuited after disinfection with mercurial salts; for it is impossible to entirely avoid, by the use of ammonium sulphide, transferring some of the material into the medium with the skin scrapings.

Schaeffer will not deny that the comparative results of the animal experiments do enable certain definite, reliable conclusions. If, for instance, twenty persons infect their hands with the most uniformly resistant, pure micrococcus tetragenus cultures possible (absolutely uniform cultures are of course unobtainable), and ten of them disinfect their hands with antiseptic A, while the other ten for the same length of time with antiseptic B; and if, say, 200 mice upon whom A is tested all succumb to tetragenus infection, while 200 other mice, upon whom B is tested, with the exception of two, survive,—the conclusion is justified that antiseptic B is better than A.

Sublamine is far less irritant than the bichloride, as has been shown in the years of usage it has had. This has been confirmed by Kruckmann and Imre in ophthalmology, and by others. Often, when our hands were infected by direct contact with pus, we have used it in 1 : 200, and 1 : 100 concentrations, and never noticed any irritations of consequence. Such sublimate solutions are intensely irritant.

In conclusion I can say the following:—

1. The fact that Sublamine in pure solution has not as strong a disinfectant action as corrosive chloride has long been known; but Schaeffer's conclusions as to the skin-disinfecting power of an antiseptic from its action in pure solution on bacteria are fallacious.

2. Besides its far greater penetration, Sublamine has the ad-

vantage over corrosive sublimate that it is much less irritant, and can be used in stronger concentrations.

3. The decisive experiments of Engels, Sarwey, Paul, Blumberg, Schenk, Zaufal, Fürbringer, Fueth, Danielsohn, Hess, and others, showing the effective action of Sublamine as a hand disinfectant, cannot be disproved by Schaeffer's experiments with Sublamine in pure solution on bacteria.

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## A CONTRIBUTION TO THE KNOWLEDGE OF ADRENALIN.

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ABSTRACT OF A PAPER OF PROF. H. PAULY.

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*Prepared at the Laboratory of the University of Bonn.*

In a continuation of his former paper on Adrenalin Prof. Pauly takes emphatic exception to the empirical formula,  $C_{10}H_{18}NO_8 \frac{1}{2}H_2O$ , proposed by Prof. Abel (Berichte, Vol. 36, p. 368), supporting rather the formula,  $C_9H_{18}NO_8$ , first proposed by Aldrich (The American Journal of Physiology, Vol. 5, 457).

In a former paper Abel was very curt (Berichte, Vol. 37, p. 368) with Pauly's analytical results, informing the readers that it is not sufficient to obtain an ashfree preparation, it must also be free from organic phosphorus; furthermore one must avoid the possible retention of ammonia, which was not impossible with Pauly. In order to overcome Abel's objections Pauly prepared an Adrenalin entirely free from organic as well as inorganic phosphorus, and found that the nitrogen-content remained the same as in his four or five previous analyses. Experiments were also carried out which showed that the Adrenalin employed for the analyses was entirely free from adherent ammonia, while the contention of Abel that Adrenalin obtained by precipitation with dilute ammonia contains adherent ammonia that is difficult to wash out is also shown to be erroneous. It is also shown conclusively by drying Adrenalin at different temperatures that



it contains no water of crystallization according to the formula  $C_{10}H_{18}NO_8 \cdot \frac{1}{2}H_2O$  (Abel). That Adrenalin contains no water of crystallization was shown also by Abel's own experimental work when he heated the same to  $145^\circ-160^\circ$  *in vacuo* without appreciable loss; but nevertheless this observation, evident as it is, did not suggest to him the only possible conclusion that Adrenalin contains *no water* of crystallization. (The formula  $C_{10}H_{18}NO_8 \cdot \frac{1}{2}H_2O$  requires 4.41%  $H_2O$ ).

What has been stated in this article together with the excellent agreement of Pauly's former analytical results suffice to show his earlier statements require in no wise a correction, and that the formula  $C_{10}H_{18}NO_8 \cdot \frac{1}{2}H_2O$  proposed by Abel is incorrect. This formula, together with the name "Epinephrin Hydrate" which designates the same, should be blotted out of the literature. The name "Epinephrin," however, should remain now as before for the basic substance obtained by treating Adrenalin with concentrated  $H_2SO_4$ , or with dilute acids under pressure, and to this the formula  $C_{10}H_{18}NO_8$  should be given. This body, whose chemical composition is different from that of Adrenalin, and whose physical, chemical, and pharmacological properties are different from the real blood-pressure-raising substance, should be considered a transformation product of the active principle.

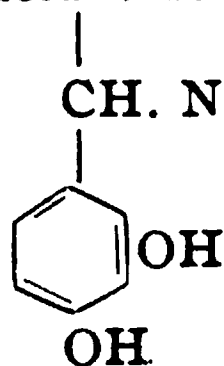
With respect to names Abel does not distinguish sharply between the designations "Epinephrin" and "Epinephrin Hydrate," although he has stated previously (Berichte, Vol. 36, p. 1846) that a body is produced from "Epinephrin Hydrate" (equivalent to Adrenalin) with alkaloidal properties (which Adrenalin does not show!), "Epinephrin." He uses in the title of his articles, however, the name "Epinephrin" exclusively. This must awake the conviction in the mind of the unsophisticated reader that the active substance of the suprarenal bears the name "Epinephrin," while it is really the name of the transformation product.

The consequence of this indefinite manner of designation has,

in the meantime, influenced Jowett (Proceedings Chem. Soc., 20, 18) to write: "Epinephrin was the name given by Abel and Crawford to the active principle of the suprarenal gland." This was of course true, until the time Abel gave this name "Epinephrin" especially to the transformation product. Jowett says later: "As Abel and Crawford were the first to isolate the active principle, although in an impure condition.—" In the interest of recorded truth Pauly objects to this. Abel has, it is true, from crude extracts of Adrenalin, thrown out, by benzoylating, an impure benzoyl product which still contained, no doubt, the original molecule; although he could not obtain from the same, by decomposition, any Adrenalin, but obtained, instead of the same, quite another thing than the original solution of the active principle. v. Fürth was more fortunate. He precipitated the active substance in the form of an iron compound, from which he could liberate crystalline Adrenalin after Takamine (in 1901) had given the method for the direct precipitation of the substance with ammonia. Thus there can be no doubt that not Abel and Crawford, but Takamine first obtained the active substance. If Abel adheres to the statement referred to in the beginning, that his formula  $C_{10}H_{18}NO_8 \cdot \frac{1}{2}H_2O$  finds confirmation in the analyses of salts and derivatives, it must be answered that that is not the case, that he, outside of one impure benzoyl product, has not prepared, not to say analyzed, up to the present time, either a salt or a derivative of Adrenalin, in which the nucleus of the last is still intact. Without doubt he means the transformation products of epinephrin described by him; but according to the experiments carried out above, the same are not conclusive.

Two derivatives of Adrenalin—Adrenalin urate,  $C_9H_{18}NO_8 \cdot C_5H_4N_4O_8$ , and dibenzoyl Adrenalin,  $C_9H_{11}NO_8 \cdot (C_6H_5CO)_2$ —were prepared and analyzed, both of which appear to confirm the formula  $C_9H_{18}NO_8$ . The difficulty in obtaining either derivative in a crystalline form accounts no doubt for the slight deviation from the theoretical values. It is also not improbable

that the benzoyl compound may be a mixture of mono- and tri-benzoyl Adrenalin. The structural formula  $\text{CH}_2\text{OH}$



is given as the most probable formula for Adrenalin, although further support for the same is desirable.—*Berichte, Mar. 31, 1904, Vol. 37, p. 1388.*

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## *Records, Recollections and Reminiscences.*

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### CORRESPONDENCE.

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*Milledgeville, Ga., August 6, 1904.*

*Dr. Deering J. Roberts, Secretary and Treasurer "Association Medical Officers Confederate Army and Navy," Nashville, Tenn.*

MY DEAR DOCTOR: With very great pleasure I renew my subscription to the SOUTHERN PRACTITIONER for the year 1904 - 05. Your journal is the recognized organ of our Association, and to *your efforts and enthusiasm* this noble body of Confederate Surgeons owes its success. Many of our members, especially those of the Army of the Tennessee and the Trans-Mississippi Department, do not realize the fact that our Association was organized in Atlanta in 1874, *not in 1898*. It was revived in 1898, on the occasion of the Atlanta Reunion of United Confederate Veterans, Dr. Stout (the Permanent Secretary of our Association, elected in Atlanta in 1874) acting as Chairman of the meeting in 1898. The revival of our Association was through my efforts, by correspondence with Dr. J. McFadden Gaston, Chief Surgeon D. H. Hill's Division, A. N. V., and Dr. Divine. I was not at

the meeting of our Association at the Fair Grounds, as I was requested by Dr. Divine and Dr. Gaston to remain at the office of the latter for the purpose of receiving, and registration of, visiting Confederate Surgeons. Our President, at the recent meeting (1904) of our Association, in his address mentions the fact that our Association was organized in Atlanta, June 20, 1874.

This meeting of Ex-Confederate Surgeons *antedates* the "Veteran's Reunions, the first one being in New Orleans, Feb. 13, 1888; the second one March 4, 1889. These two reunions of our Veterans were exclusively of the soldiers of Gen. W. H. Jackson's command. The United Confederate Veterans Camps were organized in New Orleans June 10, 1889; so you will observe the fact that our organization was in existence thirteen years prior to the United Confederate Veterans.

In the winter of 1874, after waiting since 1865 for some leading Confederate Surgeon to call our Confederate medical officers together, and recognizing their apathy in this direction, I, as the only surviving member of the immediate staff of Dr. Fafayette Guild, Surgeon and Medical Director of the Army of Northern Virginia, determined to make an effort in the organization of our Medical Officers of the C. S. A.

I accordingly wrote to the following of my personal friends in my own State, Georgia, and to others with whom I was personally acquainted, Dr. Hunter McGuire, and the leading surgeons in the Virginia Army.

The Georgia surgeons written to were: Dr. Henry F. Campbell, of Augusta, Ga.; Dr. W. A. Carswell, Rome, Ga.; Dr. W. F. Westmoreland, Atlanta, Ga.; Dr. W. L. Alfriend, Sparta, Ga.; Dr. H. F. Andrews, Washington, Ga.; I. T. Banks, Griffin, Ga.; Dr. H. L. Burt, Sparta (Mt. Zion), Ga.; Dr. W. A. Culberton, Core Spring, Ga.; Dr. M. P. Readmyer, Elberton, Ga.; W. A. Green, Americus, Ga.; Dr. I. W. Henty, (Confederate Navy) Milledgeville, Ga.; G. H. W. Hunter, Louisville, Ga.; G. M. McDowell, Barnesville, Ga.; C. B. Nottingham, Macon, Ga.; J. B. Reid, Savannah, Ga.; F. A. Stanford, Columbus, Ga.; B. M. Cromwell, Albany, Ga.; Sam Jones, Thomasville, Ga.; I. A. Butts, Bainbridge, Ga,

Thirty-two Ex-Confederate Surgeons responded to my personal letters and my call through the press of Georgia.

We met at the Capitol Building in Atlanta, June 20, 1874, and were in session for two days—a most delightful meeting.

*Organization of Association of Medical Officers of Confederate Army and Navy, Atlanta, Ga., June 20, 1874.*

SYNOPSIS OF PROCEEDINGS. (From *Daily Constitution*.)

Dr. S. H. Stout was elected temporary Chairman, and Dr. Charles Pinckney temporary Secretary.

Officers of permanent organization: Surgeon-General S. P. Moore, President; Dr. Henry F. Campbell (Georgia), Vice-President at Large; Dr. Joseph E. Claggett, Vice-President from Maryland; Dr. Hunter McGuire, Vice-President from Virginia; Dr. S. S. Salchmell, Vice-President from North Carolina; Dr. A. M. Talley, Vice-President from South Carolina; Dr. W. F. Westmoreland, Vice-President from Georgia; Dr. E. A. Holt, Vice-President from Florida; Dr. S. G. Clark, Vice-President from Alabama; Dr. S. D. Hill, Vice-President from Mississippi; Dr. E. S. Drew, Vice-President from Louisiana; Dr. J. N. Hoyden, Vice-President from Texas; Dr. Paul F. Eve, Vice-President from Tennessee; Dr. D. A. Linthicum, Vice-President from Arkansas; Dr. David W. Yandell, Vice-President from Kentucky; Dr. Lewis F. Pim, Vice-President from Missouri.

Medical Officers of the U. S. Army and Navy who resigned their position for service in Confederate States Army, Vice-Presidents at Large. Also officers of the Navy to be requested to co-operate with the officers of the Association; also that Dr. S. H. Stout of Atlanta, Ga., be Secretary, and Dr. Charles Pinckney, of Atlanta, Assistant Secretary; Dr. E. D. Newton, Treasurer.

Dr. A. O. Fox was Secretary of Committee on Permanent Organization; Dr. W. E. Goldsmith, Chairman.

*The Report Unanimously Adopted.*

The Committee on Business reported: 1. "That the Association be called 'The Association of Medical Officers of Confederate Army and Navy.' 2. That the object of said Association shall be the collection and preservation of the medical

records and statistics of the late Confederate Army and Navy, and the collection and publication of such scientific facts as may be useful to the Association and the medical profession; the preparation and publication of biographical notices of deceased members of the late Medical Staff; and the cultivation of social and friendly intercourse. Meetings to be held annually."

#### STANDING COMMITTEES.

On Hospital Service, On Field Service, On Naval Service, On Necrology, On Hygiene, On Miscellaneous Service.

Committee was appointed to prepare permanent Constitution and By-Laws to be submitted at next annual meeting. Next meeting to be held in Richmond, Va., first Monday in July, 1875.

Resolution passed that sketches of the organization and service of the Medical Officers be prepared as follows: Dr. J. D. N. Cullen, Army Northern Virginia, Field Service; Dr. Carrington, Army Northern Virginia, General Hospital Service and Organization in Richmond; Dr. E. A. Flewellen, Army of Tennessee; Dr. S. H. Stout, Organization and Service under his direction in rear of the army; all to be read at next meeting.

Dr. A. N. Talley to prepare a sketch on Army Examining Boards.

The following Chairmen of standing committees announced: On Hospital Service, Dr. J. B. McCaw, Richmond, Va.; On Field Service, Dr. D. W. Yandell, Louisville, Ky.; On Naval Service, Dr. W. H. Southwood, Pensacola, Fla.; On Necrology, Dr. I. P. Logan, Atlanta, Ga.; On Miscellaneous Reports, Dr. E. D. Newton, Athens, Ga.; On Hygiene, Dr. W. H. Cumming, Atlanta, Ga.; On Address (special committee), Dr. S. H. Stout, Atlanta, Ga.

Special Committee, consisting of Drs. E. J. Eldridge, W. S. Swin, and S. M. Bemis, appointed to prepare a paper on Medical and Sanitary History of Andersonville Prison.

Dr. Cumming was requested to prepare a paper on Vaccination and its Results as Manifested in the Army, to be read at Richmond; also that Committee on Field Service report at next meeting on the results of indigenous remedies in the Confederate Army.

A fund was raised to publish minutes of meeting, and the proposed "Address to Ex-Surgeons of the Confederacy."

*Names of Delegates handed in.*

Dr. W. J. Goldsmith, Atlanta, Ga., Dr. B. A. Holt, Lake City, Florida, Dr. W. A. Carswell, Rome, Ga., E. D. Newton, Athens, Ga., Dr. G. W. Hewell, Opelika, Ala., Dr. G. G. Crawford, Athens, Ga., Dr. Henry F. Campbell, Augusta, Ga., Dr. H. V. Miller, Atlanta, Ga., Dr. W. H. Cumming, Atlanta, Ga., Dr. W. S. Armstrong, Atlanta, Ga., Dr. W. F. Westmoreland, Atlanta, Ga., Dr. F. K. Mitchell, Lawrenceville, Ga., Dr. J. J. Knott, Atlanta, Ga., Dr. M. J. Roach, Atlanta, Ga., Dr. J. P. Logan, Atlanta, Ga., Dr. Robert Battey, Atlanta, Ga., Dr. J. Hendree, Atlanta, Ga., Dr. A. G. Emory, Opelika, Ala., Dr. S. H. Stout, Atlanta, Ga., Dr. Charles Pinckney, Atlanta, Ga., Dr. S. W. Oslin, West Point, Ga., Dr. W. A. Green, Americus, Ga., Dr. A. F. Houston, Atlanta, Ga., Dr. W. W. Francis, Jacksonville, Fla., Dr. I. M. Johnson, Atlanta, Ga., Dr. Henry L. Wilson, Atlanta, Ga., Dr. J. Steinbach Wilson, Atlanta, Ga., Dr. J. H. Logan, Atlanta, Ga., Dr. F. R. Calhoun, Euaharlie, Ga., Dr. James J. Winn, Clayton, Ga., Dr. W. C. Moore, Atlanta, Ga.

The second meeting of the Association of Medical Officers of Confederate Army and Navy met in Richmond, Virginia, the first Wednesday in July, 1875. A large number of Confederate Surgeons were present, the majority, however, were from Virginia.

The address of Dr. Samuel Moore, Surgeon-General C. S. A., our President, embraced all of the details of the Medical and Surgical Service in the field and hospital during the years 1861 to 1865. It was a most notable and interesting paper, complimenting the zeal, skill, and patriotism of the medical staff of our army and navy. It showed how the army was supplied with medicines and medical stores by capture from the Federals, by the blockade runners, and by home manufacture. This address should be placed by our Association in the hands of every Confederate Surgeon.

Dr. Hunter McGuire, the accomplished surgeon and the able Medical Director of Stonewall Jackson's Corps, A. N. V., was

elected President of our Association. His numerous duties as Professor of Surgery in the Richmond Medical College, his attention to his private sanitarium in Richmond, and his failing health prevented him from giving his personal attention to the Presidency of our Association.

The revival of our Association on the occasion of the Atlanta meeting of the U. C. V. in 1898 brought the surgeons of the Army of the Tennessee and the Trans-Mississippi to our assistance. The meetings in Charleston, Louisville, Memphis, Dallas, New Orleans, and Nashville have all been of very great interest, and we look forward to our meeting in Louisville with pleasure, hoping that we may have a large attendance and many interesting papers presented.

Wishing the SOUTHERN PRACTITIONER great success both as a journal of medicine and surgery, and as the official organ of our Association of Medical Officers of the Confederate Army and Navy, we remain

Faithfully your friend and comrade,

EDWIN D. NEWTON, A. M., M. D.

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## *Obituary.*

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### JOHN A. HICKMAN, M. D.

A simple post-master's official blank card furnished him by the the brief information that the SOUTHERN PRACTITIONER addressed to Dr. John A. Hickman, Cynthiana, Ky., was not taken out of the office. The reason given was that the doctor was dead. By addressing several letters enclosing postal card for reply, I hoped to have obtained at least the exact date of his death, but up to the time of going to press met with failure, so I can only give the brief fact of his death. Yes, another has dropped out of the ranks, and will not be with us in Louisville next year.

However, I can give some facts of his life taken from the record blank on file, and filled out by him at the former Louisville meeting.



"John A. Hickman, born Nov. 30, 1827, in Spencer County, Ky.; his post-office address, Cynthiana, Harrison Co., Ky. Entered the Confederate Army as Surgeon in 1862, first serving with the Ninth Kentucky. Subsequently served with the Sixth Kentucky Infantry, being with it at the battle of Chickamauga. At one time had charge of Dufford Building Hospital. On hospital duty afterward at Adairville, Ga. in 1864. Was on hospital service at Columbus, Ga., at the close of the war.

A brief recital—but being "facts," shows us that he was with us, and was "one of us" *all along the lines*.

## *Editorial.*

### THE ST. LOUIS EXPOSITION.

We will not call it "The Louisiana Purchase Exposition," although in commemoration of that great event. We took a few days off in the first part of September and "took in" as much of it as "our small head could hold" and feel justified in saying that it is *all* St. Louis; for she can say as was said in the earlier days of Ole Virginia, while only a colony, "I did it with my little hatchet," yes, indeed, she has done it, aye, and done it *well*. Oh my, my, my! what would the author of the citation above say if he could only see now, what was in his day only vast solitudes, disturbed alone by the wild winds of heaven, the songs and flight of birds, the growl of beasts of prey, or the cry of their victims, the various sounds of joy or pain of other wild animals of more pacific disposition, the stealthy tread of the savage who had never seen "the white man"—in fact only the sounds of nature disturbed alone by the infrequent interruptions made by the few "lords of the soil" just alluded to who occupied or visited this magnificent domain? Ah! what would he say could he but be there now? And Thomas Jefferson, his cogener whose able pen wrote the instrument that made it possible, and who later purchased from the "Little Corporal" for \$15,000,000 all the grand and now glorious territory, on 1240 acres of which alone, in a few fleeting months have been erected buildings costing more than three times the amount paid for the many thousands of acres of hill and dale, lake, river, and mountains, all then but a vast wilderness, now a magnificent area whose value now cannot be estimated by the most astute accountant—yes, indeed, what would he say, could he but see what is open to the inspection of all our citizens and the world at large?

Time, space, nor ability will permit our attempting a description of this magnificent enterprise instituted by the Missouri Historical So-

ciety to commemorate one of the most important events in the history of this country, therefore we will give a condensed statement that recently appeared in the *New York Sun*. It is as follows:—

“There is more to be seen at St. Louis than there was in Chicago in 1893, more than there was at Paris in 1900, and far more than there was at the Buffalo Pan-American. Placing them in comparison, St. Louis makes Philadelphia seem almost trivial. The area covered by buildings at St. Louis is greater than the entire exhibition grounds at Philadelphia. One-third of all that was shown at Philadelphia could be assembled inside the St. Louis Agriculture building alone, while the entire Centennial exhibit could be displayed in four of the St. Louis buildings—the Agriculture, Manufactures, Varied Industries, and Transportation, with several acres of unoccupied space left over.

“While by no means limited to these structures, the economic features of the St. Louis Fair center in seven huge buildings, the smallest of which covers about nine acres, while the largest covers about fifteen acres. In these buildings there are gathered products and processes from all corners of the earth. Machines of many kinds are in practical operation. Machines show how cotton cloth is made, and other machines show how shoes are made. There are lathes and saws and forges; there are engines of many patterns and dynamos galore; there are miles of avenues where are displayed exhibits of fabrics and of furniture, of glass and crockery, pots, kettles, and bronze vases, saddles, harness, and marble statuary, Chinese carvings, Japanese pottery, and locomotives, buggies and hearses, automobiles and vestibuled trains, bathtubs and silverware, surgical implements and mining machinery. And when the visitor has spent a few days in looking at these and the myriad of other exhibits, they are likely to be confused in his mind in some such jumble as that indicated by this list.”

To this we can most heartily say, “them’s our sentiments,” and but add, as a word of advice to our many friends and readers, go and see for yourself if you have not been there; yes, go at once, and stay not on the order of your going. The time left is but short; the preceding month was even rather warm, and October will prove the pleasantest of all, neither too hot nor too cold.

A few words of advice we will add. When you get there, if you have only a few days or a week, ten days, a month or more, to stay, for goodness sake don’t try to see it all, for you *can’t do it*. It will *do* you if you try. Take your time about it, and just see all you can. You will find plenty to interest you, doctor, whether in medicines or surgical appliances.

Among many old friends in medical lines we ran upon the beautiful exhibit of Wm. R. Warner & Co. However, we found no one in charge, although we made it several visits. On one occasion we asked one of the uniformed attendants, “Who is in charge of this?” He replied,

"I have not seen any one since I have been about it but visitors." Taking another good look we thought we could understand,—it was so handsome, so attractive, yet so well and systematically arranged it could well stand alone and take care of and speak for itself; it needed not even the blond and bland "Deacon," surnamed after a well-known household pest, to be on hand.

We took one day off our wonder gazing to see some of our good friends in the city of St. Louis. We were shown over the splendidly arranged buildings of the home of *Listerine*, by the genial A. R. Deacon — not "Warner's Specific" above mentioned. The genii and fairies we found so vigilant over the purity of the offspring of our lamented friend of days gone by, who, alas, has passed over the river of his name, it seems. but yesterday, but it was years ago.

At "Melliers" we found "Albin," who, with Mr. Walker C. Taylor, the president of the company, were as busy, as their splendid products ever demand, as they always do, yet these genial gentlemen always have time to show all the courtesies a visitor could demand. "Good wine needs no bush."

In the house that Antikammia — not "Jack" built, to our surprise, we met Frank Ruff — but he's *not* rough at all — and don't you believe it. Only a day or two before leaving home for St. Louis we had received illustrated postals from him, one from "Gay Paree," and the other from Spitzbergen, where he had been trying to catch fish with the North Pole. He had written his postals and beat them across the Atlantic. Oh, he's a hustler!

The "Big Four," Ecthol, Papine, Iodia, and Bromidia, we found in charge of — not C. S., but the other Battle. Well, they deserve their name, fighting so ably against dread disease and grim death. And ain't they doing it well? Their splendid preparations have aided me in winning many a "battle" against pain, disease, and death.

At 1718 Olive Street we saw the one and only Glazebrook. The Tilden Company could not be better represented if Samuel J. himself were out of his place and in Glaze's. We told him a little yarn that he said he was going to commit to memory so that he could make Frank Lydston laugh.

The Sultan Drug Company,— we think of them as "Seng and Cac," not Chang and Eng,—in the same house with our other friends, who are so justly proud of their products as to be entitled to their name of Peacock, were both full of business, but will take time to make you feel that way the photographer tells you to look, and they do it, if the camera man don't.

What a world of business they all do, and it is well worth a trip to St. Louis just to see how these of our friends do it. In conclusion, my good reader, if you do go to St. Louis, no matter how short your limit, do as we did, follow in our tracks, and you will never regret it.

## MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

The next meeting of this Association will be held in Cincinnati, O., on the 11th, 12th, and 13th inst. Dr. Hugh T. Patrick, of Chicago, will preside, Dr. Henry E. Tuley, of Louisville, being Secretary. The meeting will be largely attended, being in the "Queen City" of the Valley. The following *program*, it being *official*, is an assurance of the truly *scientific* and interesting character of the occasion:—

Address of the President, Hugh T. Patrick.

Address in Medicine. By C. Travis Drennen, Hot Springs, Ark.

Address in Surgery. By W. J. Mayo, Rochester, Minn.

Spleenless Men: Report of Two Successful Cases of Splenectomy. By J. H. Carstens, Detroit.

Reflection Upon the Origin of Hallucinations of Sight and Hearing. By Charles J. Aldrich, Cleveland, O.

Prevention of Conception and the Evils Thereof. By William F. Barclay, Pittsburg, Pa.

Relative Dangers of Craniotomy and Cesarean Section. By James M. Barnhill, Columbus, O.

Treatment of Diabetes Mellitus. R. Alexander Bate, Louisville, Ky.  
Prognosis. John M. Batten, Dowington, Pa.

Foreign Bodies in the Esophagus. Carl E. Black, Jacksonville, Ill.

Acute Anterior Poliomyelitis. Sanger Brown, Chicago.

A Case of Bilateral Tic Doloureux Treated by Intra- and Extra-Cranial Neurectomy. By W. O. Bullock, Lexington, Ky.

Pathologic Changes Resulting from Prostatic Enlargement. Charles E. Burnett, Fort Wayne, Ind.

Treatment of Tubercular Pleuritis. By James G. Burroughs, Asheville, N. C.

Pseudo-Membranous Croup. By Robert E. Carlton, Latonia, Ky.

Cranial Injuries. By Shelby C. Carson, Greensboro, Ala.

Echinacea. C. S. Chamberlain, Cincinnati, O.

The Value of the X-Ray to the General Practitioner. By James E. Coleman, Canton, Ill.

Report of Some Unusual Surgical Cases. By A. H. Cordier, Kansas City, Mo.

Loss of Consciousness and Automatism in Inebriety. By Thomas D. Crothers, Hartford, Conn.

The Relation of Trauma to Hernia. By Daniel N. Eisendrath, Chicago, Ill.

The Typic (Anatomic) Operation for the Radical Cure of Oblique Inguinal Hernia. By Alex. Hugh Ferguson, Chicago, Ill.

Two Factors in the Pelvic Diseases of Woman; Their Prevalence, Result and Prevention. By J. H. Firestone, Freeport, Ill.

A Plea for Better Feeding of the Patients in Our State Hospitals for the Insane. By W. B. Fletcher, Indianapolis, Ind.

- Perilous Calms of Appendicitis. By Robert Wallace Hardon, Chicago Ill.
- Prophylaxis of Appendicitis. By William M. Harsha, Chicago, Ill.
- Factitious Eruptions. By M. L. Heidingsfeld, Cincinnati, O.
- Infectious Diseases: Their Communicability, Quarantine and Prevention.  
By Henry D. Holton, Battleboro, Vt.
- Formalin in the Treatment of Amebic Dysentery and Kindred Affections.  
John L. Jelks, Memphis, Tenn.
- Report of a Case of Brain Abscess of Otitic Origin, with Some Observations. By George F. Keiper, LaFayette, Ind.
- Report of Two Cases of Amputation of Both Legs; Recovery. By F. D. Kendall, Columbia, S. C.
- Report of Two Cases of Pancreatic Cyst. By VanBuren Knott, Sioux City, Iowa.
- Extra-Uterine Pregnancy. By Florus F. Lawrence, Columbus, O.
- Report on Operative Work through the Cystoscope. By Bransford Lewis, St. Louis, Mo.
- Insanity in Relation to Obstetrics and Gynecology. By Henry F. Lewis, Chicago, Ill.
- A Contribution to the Plastic Surgery of the Urethra. By G. Frank Lydston, Chicago, Ill.
- Ectopic Gestation. H. B. R. McCall, Kansas City, Mo.
- The Mamma: Its Physiological Purposes and Finer Anatomy. By Thomas H. Manley, New York, N. Y.
- Radium: Its Therapeutic Value. By M. Metzenbaum, Cleveland, O.
- Protection of the Axillary Nerves and Vessels after Dissection of the Axillary Space. By J. B. Murphy, Chicago, Ill.
- The Obstetric Significance of the Transverse Diameter of the Pelvis. By Joseph B. DeLee, Chicago, Ill.
- Hereditary Predisposition to Tuberculosis. By Charles Louis Mix, Chicago, Ill.
- A Clinical Study of the Mental Disorders of Adolescence. By Frank C. Norbury, Jacksonville, Ill.
- Hospital Construction in American Cities. By A. J. Ochsner, Chicago, Ill.
- The Treatment of the Morphine Habit. By Curran Pope, Louisville, Ky.
- What Shall be Done with the Criminal Insane? By John Punton, Kansas City, Mo.
- Strictures of the Urethra. By A. Ravogli, Cincinnati, O.
- Foreign Bodies in the Cornea. By Dudley S. Reynolds, Louisville, Ky.
- The Transverse Fascial Incision for Operations in the Pelvis, with Report of Cases. By Emil Reis, Chicago, Ill.
- Why So Many Errors in the Diagnosis of Graves Disease? J. H. Stealy, Freeport, Ill.
- Association and Antagonism of Diseases. By Albert E. Stene, Indianapolis, Ind.

- Suppuration of Nasal Accessory Sinuses; Symptoms and Treatment. By J. A. Stucky, Lexington, Ky.
- The Recognition of Important Eye Lesions by the Practitioner. By George F. Suker, Akron, O.
- Valvotomy Versus the Clip for Cure of Obstipation. By Sterling B. Taylor, Columbus, O.
- Internal Hemorrhoids and Their Treatment. By Wells Teachnor, Columbus, O.
- A Clinical Experience. By W. W. Vinnedge, LaFayette, Ind.
- Needles, Ligatures, and Sutures; Their Uses and Abuses. By H. O. Walker, Detroit, Mich.
- The Combined Method in the Arrest and Cure of Tuberculosis. By H. B. Weaver, Asheville, N. C.
- Tenotomy of the Tendo Achillis in Partial Amputations of the Foot in Compound, Comminuted Fractures of the Tibia and Fibula. By J. R. Webster, Chicago, Ill.
- Subjective versus Objective Requirements in Surgery. By Otho B. Will, Peoria, Ill.
- Radical Cure of Hernia. By Hal C. Wyman, Detroit, Mich.
- Acute Intestinal Surgery, with Remarks on Technic. By John Young Brown, St Louis.
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THE AMERICAN MEDICAL SOCIETY for the Study of Alcohol and Other Narcotics was organized June 8, 1904, by the union of the American Association for the Study of Inebriety and the Medical Temperance Association. Both of these societies are composed of physicians interested in the study and treatment of inebriety and the physiological nature and action of alcohol and narcotics in health and disease. The first society was organized in 1870, and has published five volumes of transactions and twenty-seven yearly volumes of the Quarterly Journal of Inebriety, the organ of its association. The second society began in 1891, and has issued three volumes of transactions and for seven years published a Quarterly Bulletin containing the papers read at its meetings. The special object of the union of the two societies is to create greater interest among physicians to study one of the greatest evils of modern times. Its plan of work is to encourage and promote more exact scientific studies of the nature and effects of alcohol in health and disease, particularly of its etiological, physiological, and therapeutic relations. Second, to secure more accurate investigations of the diseases associated or following from the use of alcohol and narcotics. Third, to correct the present empirical treatment of these diseases by secret drugs and so called specifics, and to secure legislation prohibiting the sale of nostrums claiming to be absolute cures containing dangerous poisons. Fourth, to encourage special legislation for the care, control, and medical treatment of spirit and drug takers. The alcoholic problem, and the

diseases which center and spring from it, are becoming more prominent, and its medical and hygienic importance have assumed such proportions that physicians everywhere are called on for advice and counsel. Public sentiment is turning to medical men for authoritative facts and conclusions to enable them to realize the causes, means of prevention, and cure of this evil. This new society comes to meet this want by enlisting medical men as members, and stimulating new studies and researches from a broader and more scientific point of view. As a medical and hygienic topic the alcoholic problem has an intense personal interest, not only to every physician, but to the public generally in every town and city in the country. This interest demands concentrated efforts through the medium of a society to clear away the present confusion, educate public sentiment, and make medical men the final authority in the consideration of the remedial measures for cure and prevention. For this purpose a most urgent appeal is made to all physicians to assist in making this society the medium and authority for the scientific study of the subject. The secretary, Dr. T. D. Crothers, of Hartford, Conn., will be pleased to give any further information.

#### AMERICAN MEDICAL EDITORS' ASSOCIATION.

The thirty-fifth annual meeting of the American Medical Editors' Association, held at Atlantic City in June, 1904, was one of the most successful in its history., C. E. de M. Sajous, president, presiding.

The many papers presented, as well as the numerous applications received for membership, is possibly the best indication of the interest displayed in the Society. Among the new members who joined at this meeting were the following:—

Dr. Herman Knapp, editor of the "Archives of Ophthalmology," New York.

Dr. J. Madison Taylor, "Sajous Encyclopedia," Philadelphia, Pa.

Dr. Joseph McFarland, "Medicine," Philadelphia, Pa.

Dr. H. Longstreet Taylor, "St. Paul Medical Journal," St. Paul, Minn.

William Davis, "St. Paul Medical Journal," St. Paul, Minn.

Surgeon General Walter Wyman, "Sajous Encyclopedia," Washington, D. C.

Louis L. Pilcher, "Annals of Surgery," Brooklyn, N. Y.

H. Enos Tuley, "Louisville Journal of Medicine," Louisville, Ky.

Andrew Mac Phail, "Montreal Medical Journal," Montreal, Canada.

A. W. Wright, "Canadian Practitioner & Review," Toronto, Ont., Can.

E. E. Dorr, "Iowa Medical Journal," Des Moines, Iowa.

George Elliot, "Dominion Medical Monthly," Toronto, Ont., Can.

Frank B. Cross, "Lancet Clinic," Cincinnati, Ohio.

F. E. Daniel, "Texas Medical Journal," Austin, Texas.

William F. Waugh, "Alkaloidal Clinic," Chicago, Ill.

Wm. J. Robinson, "Critic and Guide," New York.

Raymond Wallace, "Southern Medicine & Surgery," Chattanooga, Tenn.  
 C. Sumner Witherstein, "Sajous Encyclopedia," Philadelphia, Pa.  
 F. W. Samuel, "American Practitioner & News," Louisville, Ky.  
 Arthur W. Patlk, "Wisconsin Medical Journal," Milwaukee, Wis.  
 Langdon B. Edwards, "Virginia Medical Semi-Monthly," Richmond, Va.  
 Clarence A. Smith, "Northwest Medicine," Seattle, Wash.  
 Horatio C. Wood, Jr., "Therapeutic Review," Philadelphia, Pa.  
 Albert E. Stern, "Medical & Surgical Monitor," Indianapolis, Ind.  
 James U. Barnhill, "Columbus Medical Journal," Columbus, Ohio.  
 Samuel F. Brothers, "Medico Pharmaceutical Journal," New York.  
 Alfred B. Meacham, "Post Graduate," New York.  
 G. L. Harrington, "Brooklyn Medical Journal," Brooklyn, N. Y.

Among the interesting papers read and thoroughly discussed, we would mention:—

"Proprietary and Patent Medicines," Harold N. Moyer, Chicago, Ill.  
 "Military Medical Journalism of the Present Day," Major J. Evelyn Pilcher, Carlisle, Pa.  
 "Sundown Journalism," T. D. Crowthers, Hartford, Conn.  
 "Medical Illustrations," H. V. Wurdemann, Milwaukee, Wis.  
 "Medical Journalism of the Pacific Coast," Winslow Anderson, San Francisco, Cal.  
 "The Medical Press vs. The Modern Plague," William Porter, St. Louis, Mo.  
 "Reading Notices," W. C. Abbot, Chicago, Ill.  
 "Imitation Journalism," H. Waldo Coe.

Following an animated discussion of Dr. Porter's article relative to the use of patent nostrums, the following resolutions, endorsing the action of Mr. Bok, editor of the "Ladies' Home Journal," were favorably acted upon:—

*Whereas*, The public is, and long has been, suffering from the use of nostrums, and from the nuisance of medicines, and,

*Whereas*, The medical profession and press have endeavored by every means in their power to instruct the laity upon the subject, and,

*Whereas*, Some journalists either do not understand the true situation, or find it to their pecuniary gain to favor the use of nostrums and pander to the greed of their manufacturers at the expense of the health or even the lives of their dupes among the people, and,

*Whereas*, The eminent editor of the "Ladies' Home Journal," Mr. Edward Bok, in an able and vigorous editorial on page eighteen of the May number of that journal, laid the truth of the matter before his readers, thus aiding in the work of warning and educating and conserving the health and welfare of the public, be it

Resolved, That the American Medical Editors' Association approves and commends Mr. Bok for the intelligent, honest, fearless, and well-



grounded position he has taken, which has been thoroughly appreciated by us and by the medical profession generally.

Resolved, That a copy of these resolutions be spread upon the Minutes of this meeting, be transmitted to Mr. Bok, and be published in the medical journals throughout the country.

Dr. Porter presented the following resolution bearing upon the death of Dr. I. N. Love, an ex-president of the American Medical Editors' Association:—

Through the joys of to-day come refrains in minor key. We welcome our friends again, but some have dropped out forever. One day eager in all that makes the activities of life—the next cold and silent on the bosom of the dark, mysterious river. Dr. I. N. Love was no ordinary man. Endowed as few are, he cultivated the art of showing to others the natural buoyance of his nature and keeping well within himself the burden and shadows that few knew of and the many never dreamed of. No one was better known in the medical societies of the country and especially in this Association. Quick, witty, generous, he made friends at every turn, and if to-day he made an enemy, to-morrow he was likely to kill him with kindness.

Of his work as a physician and as an editor, you who were his friends through the decades, need not be told. As a physician he was sympathetic and intelligent beyond the possibilities of most men. The devotion of his patients was a natural sequence following the sunshine of his presence in the sick room. As an editor he was original and personal, but his personalities were more likely to be eulogistic than censorious. He called his Journal "a reflex of the medical profession," but it was more notably a reflex of his own life.

Realizing the difficulty of expressing a just appreciation of the life of one so brilliant, so fascinating and energetic, yet in token of the sense of loss sustained by the Association, be it

Resolved, That the members of the American Medical Editors' Association, while mourning the decease of Dr. I. N. Love in the zenith of his manhood and opportunities for usefulness, remember and cherish the recollection of all in his most attractive individuality that made his record so large a part of the history of this Association.

Resolved, That a large page of our record books be set apart for the resolutions and that a copy be sent with our truest sympathy to the members of his family.

WM. PORTER.

C. F. TAYLOR.

A committee was appointed by the Chair, composed of C. F. Taylor, chairman, Dr. Hogehead of San Francisco, Cal., and Dr. Pilcher of Carlisle, Pa., and the Secretary, member ex-officio, to draft a new Constitution and By-Laws to be presented at the next meeting.

The following officers for the coming year were elected:—

President, Harold N. Moyer, Chicago, Ill.

First Vice-President, C. Evelyn Pilcher, Carlisle, Pa.

Second Vice-President, O. F. Ball, St. Louis, Mo.

Secretary and Treasurer, J. MacDonald, Jr., New York.

The Executive Committee: C. E. de M. Sajous, Chairman; John Punton, W. A. Young, W. C. Abbot, H. M. Simmons, C. F. Taylor, and Chas. Wood Fassett.

This Association now enjoys a membership of over 100 active medical editors, and those medical journalists not now associated are invited to present their applications for membership to the Secretary, Dr. J. MacDonald, Jr., 100 William Street, New York City, N. Y.

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ENDERMOL.—In a paper "On the Local Application of Formaldehyde in Dermatology" (American Journal of Dermatology, July, 1904), Dr. August Ravogli, Professor of Dermatology and Syphilography, Medical Department Cincinnati University, makes repeated favorable mention of Endermol. He has used it with very good results as a vehicle for ichthoform, empyroform, etc. An Endermol ointment containing 1 to 2 per cent. ichthoform acted very well in two cases of infantile eczema. Empyroform, which has been praised by the clinics of Professor Nicolaier at Goettingen, Prof. Neisser at Breslau, and Prof. Pick at Prague, was successfully used as an ointment with Endermol in several cases of eczema. In some cases of squamous eczema, where a 1 to 5 per cent. Empyroform-Endermol ointment was used, the results obtained were also in accord with those reported by the above-named clinics. It diminished the itching sensation, removed the scales, and restored the epidermis to a normal condition. The Empyroform-Endermol ointment was also used to conclude the treatment in infantile eczema, but there the effects were not so satisfactory.

With 1 to 10 per cent. formo-resorcin, Endermol makes a soft, homogeneous, slightly pinkish salve which is easily spread on cloth for application. The combination was used in leg ulcers and psoriasis.

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EMPYROFORM.—In a clinical lecture on skin affections in children, Dr. W. S. Gottheil, Dermatologist to the City, Lebanon, and Beth Israel Hospitals, New York, exhibits amongst others a case of psoriasis nummulata. The local treatment consists in the first place in the thorough removal of the scales by means of a hot-water-green-soap bath and a scrubbing brush; this must be repeated from time to time as the necessities of the case demand. Of late he has been using tar very much more than chrysarobin, which was the favorite application some time ago. Tar is less likely to excite dermatitis and does not have quite so dreadful an effect on the patient's clothes and general comfort. Rectified birch tar (*oleum rusci*)

10 per cent., in olive oil or vaseline, will do very well; the proportion of tar is to be increased as the susceptibility of the patient's skin is ascertained. During the last winter he has been using a tar-formalin preparation called empyroform a good deal in these cases, and is satisfied with its effects. He prescribes for the cases in question a 5 per cent. empyroform-vaselin ointment, to be thoroughly rubbed in with a bristle brush on all the spots twice daily. The time required to clear the body should not be more than three weeks.

Abstracted from the Archives of Pediatrics, June, 1904 (Vol. 21, No. 6, p. 426).

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A CALMATIVE AND NERVE TONIC.—For nervous irritability and insomnia, accompanying the menopause, Daniel's Conct. Tinct. Passiflora Incarnata should be administered in teaspoonful doses every hour, gradually lengthening the intervals as the nervousness is controlled. Its action is especially gratifying with neurasthenic patients. It relieves neuralgia, and gives results where other calmatives are powerless.

Several cases recently reported of hysteria and sleeplessness in patients of all ages, due to dissipation, over-work, and other causes, indicate that the practitioners are obtaining splendid cures from Passiflora, and dwell with emphasis on the fact that no bad after-effects are encountered.

Passiflora gives quietude and refreshing sleep, and may be employed with assurance in all affections of the nervous system.

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THE NEW YORK SCHOOL OF CLINICAL MEDICINE announces the following changes in faculty: General Medicine, Profs. Wm. Brewster Clark and Henry Lawrence Schively; Associate Professors, Thos. M. Acken and Edward L. Kellogg; General Surgery, Prof. Simon J. Walsh, and Associate Professor J. Cameron Anderson; Gynecology, Profs. Augustin H. Goelet and A. Ernest Gallant; Pediatrics, Profs. Dillon Brown and Henry Comstock Hazen; Nervous and Mental Diseases, Profs. J. Arthur Booth and Emmet C. Dent; Gastro-Intestinal Diseases, Prof. Robert Coleman Kemp; Ophthalmology and Otology, Profs. John L. Adams and George Ash Taylor; Dermatology, Prof. Robert J. Delvin; Laryngology and Rhinology, Prof. Max J. Schwerd; Orthopædic Surgery, Prof. Homer Gibney; Hydrotherapeutics, Prof. Alfred W. Gardiner; Genito-Urinary Diseases, Profs. Wm. K. Otis, Walter Brooks Brouner, and John von Glahn; Pathology, Prof. E. E. Smith. The facilities of the School have been materially enlarged. JOHN L. ADAMS, M. D., *Secretary*.

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MEDICAL PRACTICES.—Those of our readers who wish to buy or sell a medical practice, or desire an assistantship or partnership, can obtain a list of practices for sale, and all further information, free of charge, by addressing *The Medical Echo*, Lynn, Mass.

COMMENT ON ANTIKAMNIA AND HEROIN TABLETS.—Under the head of "Therapeutics," the *Medical Examiner* contains the following by Walter M. Fleming, A. M., M. D.,\* regarding this valuable combination: "Its effect on the respiratory organs is not at all depressing, but primarily it is stimulating, which is promptly followed by a quietude which is invigorating and bracing, instead of depressing and followed by lassitude. It is not inclined to affect the bowels by producing constipation, which is one of the prominent effects of an opiate, and it is without the unpleasant sequels which characterize the use of morphine. It neither stupifies nor depresses the patient, but yields all the mild anodyne results without any of the toxic or objectionable phases.

"When there is a persistent cough, a constant 'hacking,' a 'tickling' or irritable membrane, accompanied with dyspnoea and a tenacious mucous, the treatment indicated has no superior. In my experience I found one 'Antikamnia and Heroin Tablet,' every two or three hours, for an adult, to be the most desirable average dose. For night-coughs, superficial or deep-seated, one tablet, on retiring, if allowed to dissolve in the mouth, will relieve promptly, and insure a good night's rest. In short, it will be found futile to delve for a more prompt and efficient remedy than 'Antikamnia and Heroin Tablets' in all bronchial complications with laryngeal irritation, dyspnoea, asthma, winter-cough, and general irritability of the thoracic viscera."

\*Qualified Examiner in Nervous and Mental Diseases for Supreme Court, New York City.

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"LEARNING gives temperance to youth; affords comfort to old age; yields riches to the poor; and is an aid and ornament to the rich."—*Diogenes*.

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PAIN.—Lord Lytton said, "There is purpose in pain." How true is the fact, especially from a diagnostic point in diseases of women. Dysmenorrhea, that distressing manifestation of uterine obstruction, most frequently caused by congestion, is only one of the many instances. To equalize pelvic circulation and remove uterine engorgement is the object to be attained, and is best accomplished by administering Hayden's Viburnum Compound. Dr. James Charles Copeland says in his "Medical Treatise" in the chapter on "Menstrual Life of Women," "For Dysmenorrhea, characterized by sharp, colicky pains, there is nothing better than Hayden's Viburnum Compound."

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WHEN TO OPERATE IN APPENDICITIS.—Now or later? That is the question. While undecided, use Antiphlogistine. Spread warm and thick over the abdomen, and cover with absorbent cotton and a suitable compress. When used early the inflammation is often resolved, the attack

is cut short, and operation becomes unnecessary. The dressing should be renewed when it can be easily peeled off, generally in twelve to twenty-four hours.

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WE CANNOT SPEAK TOO HIGHLY OF TROPHONINE. We believe if typhoid and other diseases of the digestive tract, or any portion of it, to say nothing of pneumonia and other diseases of an acute form, were treated with absolute fasting with the exception of some such remedy, or food, as Trophonine, for a period of from five to twenty days, the deaths from these diseases would be astonishingly less frequent.

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CELERINA AND ALETRIS CORDIAL RIO, equal parts, teaspoonful every four hours, is a most efficient remedy for amenorrhea.

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NEW ORLEANS POLYCLINIC:—*Eighteenth Annual Session opens November 7, 1904, and closes May 20, 1905.* Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory and cadaveric work.

For further information address, New Orleans Polyclinic, Post-office box 797, New Orleans, La.

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## *Reviews and Book Notices.*

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LEA'S SERIES OF MEDICAL EPITOMES:—NAGEL'S EPITOME OF NERVOUS AND MENTAL DISEASES. A Manual for Students and Physicians. By Joseph Darwin Nagel, M. D., Consulting Physician to the French Hospital, New York. In one 12 mo volume of 276 pages, with 46 illustrations. Cloth, \$1.00 net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1904.

Busy practitioners and all medical students should with one accord give their most hearty thanks to Dr. Nagel for having so successfully and satisfactorily gathered the various facts and data contained in the numerous text-books and pamphlets on the diseases of the mind and nervous system, and woven them into a compact fabric, easily studied by those who are in search of precise information.

There is not a single author or lecturer of high standing,

whose teachings have not been incorporated in a condensed form into the pages of this volume, which is just *splendid*.

LEA'S SERIES OF MEDICAL EPITOMES: MAGEE AND JOHNSON'S EPITOME OF SURGERY. A Manual for Students and Practitioners. By M. D'Arcy Magee, A. M., M. D., Demonstrator of Surgery and Lecturer on Minor Surgery; and Wallace Johnson, Ph.D., M. D., Demonstrator of Pathology and Bacteriology in Georgetown University Medical School, Washington, D. C. In one 12 mo volume of 295 pages, with 129 engravings. Cloth, \$1.00 net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1904.

The authors and editors have made an earnest endeavor to furnish an authoritative, clear, compact presentation of the essentials of modern surgery. While this little volume is by no means intended to take the place of a text-book, it will be found convenient for study many times, when a large book is inaccessible, while for students' use in quizzing themselves or each other, in preparation for college or State Board examinations, it will be of the utmost service.

EXAMINATION OF THE URINE. By G. A. de Santos Saxe, M. D., Pathologist to the Columbus Hospital, New York City. 12mo volume of 391 pages, fully illustrated, including 8 colored plates. Philadelphia, New York, London: W. B. Saunders & Company, 1904. Flexible leather; \$1.50 net.

Dr. Saxe has presented a work on examination of the urine unusually complete, absolutely up to date, concise, yet explicit in all its parts; and it will be found to meet fully the requirements of the student and practitioner. Special attention has been paid to the interpretation of findings as applied to clinical diagnosis, and the student is told what each chemical element and each microscopic structure means when found in the urine. The character of the urine in various diseases is also described in detail. Descriptions of technic have been made very explicit, and the author has inserted some new methods of working developed in his own experience. Cryoscopy and other means of functional diagnosis have been given their proper places. The text is fully illustrated, including eight colored plates of the various urinary crystals. The work will be useful because it is practical.

**SAUNDERS' QUESTION COMPENDS:—ESSENTIALS OF CHEMISTRY, ORGANIC AND INORGANIC.** Containing also questions on Medical Physics, Chemical Philosophy, Medical Processes, Toxicology, etc. By Lawrence Wolff, M. D., formerly Demonstrator of Chemistry at the Jefferson Medical College, Philadelphia. Sixth edition; thoroughly revised. By A. Ferree Witmer, Ph.G., formerly Assistant Demonstrator in Physiology at the University of Pennsylvania. 12mo volume of 225 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Company, 1904. Cloth, \$1.00 net.

We need but mention the fact that this little work has reached its sixth edition to prove beyond question its practical usefulness. The recent important discoveries in physics and inorganic chemistry have rendered it necessary, in Dr. Witmer's revision, to make extensive additions almost to every part of the work. The subject of organic chemistry, especially organotherapy and the substituted ammonias, has also been carefully revised and much new matter added. We find the book unusually excellent.

**A TEXT-BOOK OF CLINICAL DIAGNOSIS. By Laboratory Methods.** For the use of Students, Practitioners, and Laboratory Workers. By L. Napoleon Boston, A. M., M. D., Associate in Medicine and Director of the Clinical Laboratories of the Medico-Chirurgical College, Philadelphia; formerly Bacteriologist at the Philadelphia Hospital and at the Ayer Clinical Laboratory of the Pennsylvania Hospital. Octavo volume of 547 pages, with 320 illustrations, many of them in colors. Philadelphia, New York, London: W. B. Saunders & Co., 1904. Cloth, \$4.00. net; Sheep or Half Morocco, \$5.00. net.

Dr. Boston here presents a practical manual of those clinical laboratory methods which furnish a guide to correct diagnosis, giving only such methods, however, that can be carried out by the busy practitioner in his office as well as by the student in the laboratory. He has given special attention to outlining in progressive steps the various procedures in clinical technic, such steps being illustrated whenever possible. All the more recent methods for the examination and staining of the blood are described and illustrated by original drawings, and the subject of Serum-Diagnosis is very carefully considered. The newer methods for the estimation of Sugar, Bence-Jones's Albumin, Uric Acid, and Purin have received thoughtful consideration. The subjects of Animal Parasites, Diseases of the Skin, Transudates and Exudates, and Secretions of the Eye and Ear have

received an unusual amount of space. Attention has also been paid to Inoscopy and Cyto-diagnosis. Indeed the book contains much useful material throughout, and being the latest work on Clinical Diagnosis, includes the most recent advances along that line.

**THE GAZETTE POCKET SPELLER AND DEFINER.** English and Medical. Second edition. New York. The Gazette Publishing Company, 35 West 42d Street. (50 cents.)

This little brochure of 216 pages is so compactly arranged that it can be slipped into the vest pocket. Nearly half the work is medical, and while of course it is not so full as more voluminous works, yet it contains the larger portion of the medical terms which are sought by the average reader for information as to spelling and definition. Medical students and drug clerks will find it exceedingly useful.

**THE THEORY AND PRACTICE OF INFANT FEEDING,** with notes on development, by Henry Dwight Chapin, A. M., M. D., Professor of Diseases of Children at the New York Post-Graduate Medical School and Hospital; Attending Physician to the Post-Graduate, Willard Parker, and Riverside Hospitals; Consulting Physician to the Randall's Island Hospital. Second edition, revised, with numerous illustrations, 8 vo, Cloth, 342 pp. Wm. Wood & Co., Publishers, New York, 1904.

This valuable book has been thoroughly and carefully revised, and much of it has been re-written and extended, this second edition showing most clearly what a peculiar and distinct position artificial feeding of infants has attained in the field of dietetics.

Dr. Chapin is fully in accord with the leading standard authorities of the day, and while much has been done in recent years looking to the employment of substitute foods for infants, in this work the special function of milk in developing the digestive tract of the child is most carefully treated. Very important discoveries pertaining to cow's milk have recently been made, and the physiology of milk, together with the true principles of artificial feeding, is very carefully and ably considered.

The clear, beautiful print, fine paper, and mechanical execution of the volume are all well in keeping with the well-known establishment of Messrs. Wm. Wood & Co.



**A HANDBOOK OF PATHOLOGICAL ANATOMY AND HISTOLOGY**, with an introductory section on Post-Mortem Examinations and the Methods of Preserving and Examining Diseased Tissues. By Francis Delafield, M. D., LL.D., Emeritus Professor of the Practice of Medicine, College of Physicians and Surgeons, Columbia University, New York; and T. Mitchell Prudden, M. D., LL.D., Professor of Pathology, and Director of the Department of Pathology, College of Physicians and Surgeons, Columbia University, New York. Seventh edition, with thirteen full-page plates, and 545 illustrations in the text in black and colors; 8vo, cloth, pp. 885. William Wood & Company, Publishers, New York, 1904.

Who does not know Mitchell and Prudden in this day and age who has made any pretensions to a successful study of medicine? yes, and to love them for the grand book they have given to the medical world.

Dr. Prudden states that "Dr. Delafield no longer shares in the preparation of the work; so that the writer, deprived of the wise counsel and large experience of the senior author, is alone responsible for such alterations and additions as have been made in this as in the last revision." Yet he has received valuable assistance from Professors Francis C. Wood, Frederick R. Bailey, Eugene Hodenpyl, P. H. Hiss, Jr., Dr. John H. Larkin, and other able collaborators.

The book has been largely revised. The section on immunity has been entirely rewritten. Ehrlich's 'side chain' hypothesis has been set forth with considerable detail, as well as the new lore relating to various phases of cytolysis. However, it needs no praise at our hands. Its many excellencies have been so long known that any words of praise would be like painting the lily or refining pure gold. We will say, however, that its many and varied illustrations have not, and cannot, be excelled.

**CLINICAL URINOLOGY.** By Alfred C. Croftan, M. D., Professor of Medicine, Chicago Post-Graduate Medical College and Hospital; Physician-in-Chief to St. Mary's Hospital, and Pathologist to St. Luke's Hospital. Illustrated, pp. 298, 8vo., cloth. William Wood & Company, New York, Publishers, 1904.

This book, as the title, "Clinical Urinology," indicates, is a

treatise on the urinary aspect of disease. It is in no sense meant to be merely a laboratory guide to the analysis of urine; nor is it intended to be a purely clinical disquisition on the disorders that produce urinary abnormalities. Its purpose is to describe the borderland that lies between the laboratory and the clinic, and it does it well.

It is an excellent elucidation of the relationships of the biological and clinical interpretations of facts to normal physiology, and to physiology perverted by disease.

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### *Selections.*

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CHOREA AND ANEMIA.—In the etiology of chorea, nothing is noted relative to anemia. It is simply accounted as an accompanying symptom of the condition. Medical literature emphasizes the relation between rheumatism and chorea, with anemia as an important symptom. After observation of several cases, I am strongly of the opinion, however, that anemia as a causative factor is worthy of investigation.

Anemia of toxic origin presents pathological conditions which favor the production of choreaic affections. It is true that simple anemia is, as a rule, of secondary origin, and, viewed in this light, it may be argued that if chorea arises, it is the result of the primary and not of the secondary conditions — thus agreeing with the admitted etiology. This argument, however, will not satisfactorily explain those cases of chorea which arise remotely from the primary condition, but recently from the secondary effects.

I submit three cases in which symptoms, treatment, and recovery seem to intimate at least a possible relation between anemia and chorea.

CASE I. A female child of eight years gave a history of typhoid fever eight months prior to my visit. According to the

mother's statement, the child had made a quick and good recovery, gaining rapidly in weight and exhibiting the energy of her former life. Six months later she became irritable and pale, with pain in her arms and legs, which condition was soon followed by gastric disorders and irregular spasms of the muscles of the face. Simple anemia was in evidence from objective and subjective symptoms alone, but was unquestioned in the light of the results obtained from blood examination — the red blood element being present to the extent of barely 3,000,000 red corpuscles per c. m.

This case was treated with two teaspoonfuls of Pepto-mangan (Gude) and two drops of Fowler's solution, three times a day. After gastric symptoms had abated somewhat, two raw eggs per day were added to the diet. The patient was discharged in five weeks, completely recovered.

CASE II. A female child of ten years of age: gave history of malaria (a well-defined case of intermittent fever) one year previously. The pallid condition of the child induced the mother to solicit my aid. Upon examination, I found slight choreaic movements which had escaped the mother's eye, though she did admit that the child "could not sit still very long at a time," and "was constantly working her fingers." The blood examination revealed no plasmodium. The red cells were reduced to 2,800,000 per c. m., with a proportionate decrease of hemoglobin.

Pepto-mangan (Gude) alone was employed in doses of two drams in a glass of milk three times a day. The blood examination four weeks later showed red cells present to the amount of 3,900,000 per c. m., at which time I dismissed the case completely recovered.

CASE III. A female child of thirteen years. Two months before my visit, the mother informed me, the child became peevish and pale, and was reproved at school for her inability to write neatly. She was taken from school, but she grew rapidly worse. Morning nausea, vomiting, headache, and anorexia were her daily companions. I found her with pronounced histrionic spasm with involvement of the upper and lower extremities. Hemic murmurs were plainly apparent, but no endocardial irritation could be determined. The blood count showed reduc-

tion in red cells to 2,100,000 per c. m. The hemoglobin was reduced to a degree greater than the red cells. A curious feature of the case was the morning nausea. Immediately upon awakening, she experienced nausea, which was followed by vomiting. I discovered, however, that this condition was superinduced by odors from the kitchen, and directed that a small sponge, moistened with creosote water, be placed over the nose and mouth before the preparation for breakfast began. The annoying symptom was promptly checked by this simple method. The anemia in this case may have been produced by malnutrition, but even this view is mere speculation.

The irritability of the stomach in this case was so pronounced that I did not deem it wise to give nourishment — not to speak of medicine — by the stomach. During the first four days rectal alimentation was employed. A nutritive enema, consisting of four ounces of peptonized milk and two drams of Pepto-mangan (Gude), was given every six hours. Small amounts of peptonoids with creosote on ice were given by the stomach. Egg albumen was taken in all the water she drank. After four days, the stomach was tested with small amounts of milk and Pepto-mangan (Gude). Beginning with four ounces of milk and one dram of Pepto-mangan (Gude) every four hours, the amounts of each were rapidly increased, until after three days the patient was taking eight ounces of milk every two hours and four drams of Pepto-mangan (Gude) three times a day. This diet, plus three raw eggs a day, together with the above treatment, was all that was employed for six weeks. The blood examination at this time showed a highly gratifying condition — the red cells being present to the extent of 4,100,000 per c. m. The bloom of youth once more tinted the cheek, and the shrine of St. Vitus lost a visitor.—*Roshier W. Miller, M. D., Ph. G., Barton Heights, Va., in Virginia Medical Semi-Monthly.*

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**DIAGNOSIS OF FUNCTIONAL HEART MURMURS.**—Functional murmurs as first described by Laennec, are soft and blowing in character, occurring most commonly in the position of the pulmonary area, opposite the left costal cartilage, and are in no way

connected with valvular diseases. They are due not to anæmia as so often taught, but to a condition of hypotonus of the muscles of the circulatory system. That is, there is a relaxation of the sphincter muscles guarding the mitral and tricuspid orifices, and permitting of a leakage. In the pulmonary area, the fibrous band around the orifice permits of no dilatation, but the muscular construction of the pulmonary artery permits it to dilate, and consequently we have a condition in which the blood stream flows from one chamber, that is the right ventricle, through a relatively constricted orifice, into the dilated pulmonary artery. This is the most favorable arrangement for the production of a murmur. Dr. Rudolf laid down the following rules to aid in the diagnosis of functional from organic murmurs:—

1. They occur in adolescence and young adults.
2. They are more common in males than in females.
3. They all occur during the ventricular systole.
4. While the pulmonic area is the most common situation for functional murmurs, it is a rare site for organic murmurs (congenital stenosis being the only one found).
5. Functional murmurs are heard in the neck, *e. g.*, Bruit de Diable.
6. As the general health improves, functional murmurs tend to disappear, organic murmurs, on the other hand, tend to get louder with increasing strength.
7. Functional murmurs are soft, and accompany rather than displace the first sound.
8. They are not so widely propagated as are organic murmurs.
9. They vary under certain conditions, *e. g.*, they are louder after exertion, and are especially increased on lying down.
10. The pulmonic second sound is accentuated early, even before the murmur is heard; this is not so in organic pulmonary stenosis.
11. They are accompanied with little signs of dilatation or displacement of the apex.
12. Cardio-respiratory sounds are sometimes mistaken — ask the patient to hold his breath and they will disappear.

13. Signs of failing compensation are rare in functional cases.

14. The patients are not conscious of the existence of the murmur. An analysis of the patients in the surgical wards of the H. S. C. showed that in sixty per cent. functional murmurs were present. An analysis of a number of wards in the T. G. H. and St. Michael's Hospital showed the existence of functional murmurs in fifty per cent. of the patients.

15. Fever gives rise to functional murmurs. They occur in sixty-six per cent. of scarlet fever cases, and are apt to occur in rheumatic fever. A useful rule in this connection is: "functional murmurs tend to occur late in fever( *e. g.*, rheumatic fever) while endocardial murmurs appear within the first ten days."

16. Pressure has not much effect as a rule in altering functional murmurs.

Finally, we are all too apt to conclude that there is organic disease when we hear a murmur, and we are too easily soothed into believing the patient organically sound when no murmur can be discovered.—*Dr. R. D. Rudolf, of Toronto, in Canada Practitioner.*

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THE RESULTS OF X-RAY TREATMENT.—By Samuel Beresford Childs, A.B., M.D., Denver, Col., Professor of Anatomy, Denver and Gross College of Medicine; Surgeon to Mercy Hospital.

In the valuable paper of Dr. Childs he deals only with the facts in regard to the use of the X-ray, and reports a number of interesting cases treated by him for different diseases supposed to be amenable to the ray. In his report he concludes with the following remarks:

First. The therapeutic field of greatest usefulness of the X-ray is with the superficial epithelioma, redolent ulcer and lupus vulgaris, when the area involved is conspicuous, as on the face or neck, and where the cosmetic result is particularly to be desired.

Second. Healing by the X-ray leaves the smallest and least perceptible scar; for when properly applied it destroys only diseased tissues, and particularly commends itself for use in those localities where it is undesirable to sacrifice the surrounding tissues.

Third. The X-ray is very efficacious in many obstinate cases which have resisted the ordinary methods of treatment, such as acne rosacea, chronic localized patches of eczema and psoriasis, lupus erythematosus and kindred skin diseases.

Fourth. The results in tuberculous glands, when no suppurating focus is present, are encouraging, and the enlarged masses of glands in Hodgkin's Disease appear to be susceptible to the treatment.

Fifth. The X-ray should not be applied to any operable, deep, malignant growth, with two exceptions: First, as pointed out by Coley, where an operation would sacrifice an extremity, and even in this case the value of the X-ray is uncertain, and is determined by a few weeks' trial; second, as pointed out by Pusey, with a view to limiting the operation by checking the growth when immediate operation is inadvisable.

Sixth. The ray may be of service in inoperable malignant growths by relieving pain, diminishing discharges, and lessening their offensiveness, and in many cases life may be prolonged in comparative comfort for a considerable time. Furthermore, from these apparently hopeless cases a number of remarkable improvements and a few recoveries have been reported.

Seventh. The rays should be used as a prophylactic against return after all operations for the removal of deep malignant growths.

Eighth. The area of exposure should be wide, and the intensity and quality of the rays should be adapted to each case.

It can be readily seen that in dealing with the X-ray in the treatment of disease we are dealing with a very powerful agent, capable of doing a vast amount of good when properly applied, but fraught with danger to the patient when used by the inexperienced, and to the operator when used in long experimentation. In the successful use of the rays we must have learned thoroughly by experience the intensity and quality of light which is best adapted to each individual case, also the proper distance of the light from the surface, and the length of the exposure required. The operator sails between Scylla and Charybdis, for too weak

light will not produce results, and may even act as a stimulus to the growth, while too strong a light vigorously applied to an extensive surface where a large amount of tissue is liable to break down, may overwhelm the system with a fatal toxemia.

In the use of the rays in malignant growths involving the internal organs, other than to lessen the pain and the discharge, very little is to be expected from its use, and, to summarize, the sooner all operable cases are tackled with the knife in a merciless way, and the X-rays saved to the last to be used as a prophylactic against recurrence, the better the chances for the non-recurrence of the growth.—*New York Medical Journal*.

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HEREDITY AND CANCER.—Authorities have differed widely on this subject, but most of them agree that the probability of cancer is greater in one whose ancestry showed a history of malignant tumor, and all life assurance companies investigate this point fully. The earlier statistics seemed to show that cancer was a family disease. Paget, for example, found, in 1857, from an examination of 411 patients, that there was a probable hereditary transmission in twenty-two per cent. Lichtenstern placed the figures at seventeen per cent., while nearly all other tables compiled show that a patient with a family taint is from ten to twenty per cent. more likely to have cancer.

But now comes the archives of the Middlesex Hospital (1904), in which Prof. Karl Pearson, by biometric methods and the construction of "skew curves," arrives at quite a different conclusion. Out of 2,368 female cancer patients, 359 had a history of cancer — 15.1 per cent., as against 13.5 per cent. among the ordinary rate, the non-cancerous patients. From these statistics, as valuable as any that have been compiled, we may feel safe in advising our patients with cancerous relatives, that they have no reason to feel alarmed about their own susceptibility to the disease. Inheritance is probably of little importance.

Prof. Pearson also brought out another interesting fact:—That the onset of the disease is later in males than in females by nearly six years. In women the average age was 43.8; in men, 53.3 years.—*F. A. C., in Canada Practitioner*.



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℞. Pulv. acidi salicylici  
Pulv. zinci carb. precip. aa..... ʒij  
Pulv. magnessii ustæ..... ʒiij  
Pulv. amyl..... ʒiiss

M. Sig.: Apply as a dusting powder.—*Kansas City Medical Record.*

### HERPES PROGENITALIS.

Arostam (*Medical Times*) says that the treatment of this condition consists in the application of a boric acid wash containing a little alcohol, followed by the use of the following ointment:—

℞. Acid boric..... ʒss  
Zinc oxide  
Pulv. amyl, aa..... ʒj  
Vaseline..... ʒi

M. Sig.: Apply on cotton as directed.—*Philadelphia Medical Journal.*

5

1. The first part of the document is a list of the names of the persons who have been appointed to the various offices of the city.

2.

3.

4.

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Regarding after treatment of malaria, the following is most excellent:—

R. Tinct. fer. mur..... fl. ℥j  
 Strych. sul..... gr. j  
 Liq. arsen. potass..... ℥ij  
 Tinct. capsici..... ℥iij  
 Acid. phos. dil..... ℥iij  
 Glycerin, q. s. ad..... ℥viiij

M. Sig. One teaspoonful three times a day in water.  
 Protect teeth with quill or alkaline wash. Label "Shake."

For children I decrease the iron and strychnine according to age, and for infants the acid one half. Keep the bowels well open and the skin active by frequent cleansing. If the chills return while taking the tonic, stop it and check them with quinine; then give tonic again. This combination is one I have used for fifteen years.— *Bell, in Medical World.*

## GONORRHOEA.

R. Saloli..... ℥iv

Ft. chart. No. xxiv. Sig.: One powder an hour before meals.

Indications.— Used in acute and subacute gonorrhœa.— *E.r.*

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tificate), cut out this advertisement, attach the certificate and mail both to us and we will send you free of charge, one of these elegant Hypodermic Syringes which sell everywhere for \$2.50 each; this offer for one time only to each physician, afterward the certificate will be redeemed according to our regular plan. Write for our premium catalogue and see how we are able to make such elegant presents to our customers. If you can not get Bronchiline of your jobber, send us \$2.50 and this advertisement and we will ship you the Bronchiline and Hypodermic Syringe, you paying the Expressage.

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### TREATMENT OF SCARLET FEVER.

For the reduction of temperature in scarlet fever, Skaife (*Medical Sentinel*, 1904, Vol. XII, p. 162) prefers hydrotherapy, for the mild cases sponging with cold water, or for the high temperatures the cold pack or the cold bath. The use of antipyretics, especially aconite, ammonium acetate and potassium citrate may also be used in conjunction with these measures. For sore throat he recommends frequent spraying with

R. Acidi carbolici cryst..... 3ss  
Glycerini..... 3fl.i  
Aquæ destil, q. s..... 3vi

If there is much exudate the following mixture may be applied to the inflamed area with a camel's hair brush:—

R. Acidi carbolici..... gr. iiii  
Liq. ferri sub sulphatis..... 3i  
Glycerini..... 3vi

In order to encourage the elimination of the toxins, calomel should be used to keep the bowels open, and to eliminate them through the kidneys the free use of water should be encouraged. Lemonade and other fruit juices frequently encourage the patient to drink larger quantities than would otherwise be acceptable. Where there is a marked glandular involvement, suppuration may be frequently avoided by the local application of

R. Ichthyol  
Plumbi iodidi..... aa grs. i  
Ammonii chlorid..... grs. xv

M. Ft. unguentum. Sig.: Apply night and morning, and cover with a hot cloth.

Calcium sulphide is also a useful remedy for the purpose of preventing suppuration, the cause of failure with it is frequently due to an insufficient dose. He prescribes for an adult one grain every three hours, for two days, and one-sixth grain every three hours, children in proportion.—*Therapeutic Review*.



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### HEMORRHAGE.

Moore, in the *Practitioner*, recommends absolute rest for the patient and for the bowels, obtained by withholding food for several hours, and by the free use of opium, preferably in the hypodermic injections of morphia or the following:—

℞. Acidi tannici..... gr. x  
Tincturæ opii..... m. x  
Spiritus terebinthinæ..... m. xv  
Mucilaginis acaciæ..... ℥ii  
Tincturæ chloroformi comp..... m. xx  
Aquæ menthæ piperitæ q. s. ad..... ℥i

M. Sig.: Teaspoonful at one dose; or the following to prevent meteorism and aid in checking hemorrhage:—

℞. Spiritus terebinthinæ  
Spiritus etheris nitrosi  
Spiritus chloroformi, aa..... ℥ii  
Emulsii amygd. q. s. ad..... ℥vi

M. Ft. mistura. Sig.: Shake bottle and give tablespoonful at a dose every three to four hours as required.

An ice bag is laid over right side of abdomen; when hemorrhage is so profuse as to threaten life, ice water enemata or a hypodermic injection of salt solution may be employed; in such cases twenty grains of chloride of calcium every few hours are of value.

Hare recommends the following formula for the diarrhea of typhoid:—

℞. Acidi sulphurici aromati..... ℥i  
Extracti hematoxyli fluidi  
Spiritus chloroformi, aa..... ℥ii  
Syrupi zingiberis q. s. ad..... ℥iii

M. Sig.: Two teaspoonfuls every two to four hours.

### GRANULAR PHARYNGITIS.

℞ Iodi..... 0.40  
Potassi iodidi..... 0.80  
Syr. menth. pipis..... 50.00  
Aq. dest..... 250.00

M. Sig.: Gargle. If too irritating, add an equal quantity of water.—*Journal de Médecine*.



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### *Original Communications.*

#### **CALCULUS IN THE KIDNEY.\***

BY LUCIUS E. BURCH, M. D., OF NASHVILLE, TENN.

Nephrolithiasis signifies a stone located in the renal tissue or in the pelvis of the kidneys. The relief for this condition by surgical procedure and the perfection of the operative technique is due to Dr. Henry Morris, of Middlesex Hospital, England, who in 1880 exposed the kidney by an oblique incision in the loin, and cut through what seemed to be normal renal tissue, removing a calculus weighing 31 grains. He suggested as a name for the operation, Nephro-Lithotomy, unaware that Hevin had used the term over one hundred years before.

Nephrolithiasis is by far the most frequent and at the same time the most painful of all surgical conditions affecting the kidney, and yet the operation for its relief has a very low mor-

\* Read at regular Meeting of Nashville Academy of Medicine, Oct. 4, 1904.

pyuria, possibly with gastro-intestinal disturbance, nausea, and vomiting, with shock or collapse. The symptoms of renal colic are quite characteristic, although almost similar symptoms may be caused by movable and displaced kidney, or by an accumulation of uric acid or oxalates in the pelvis of the kidney.

The pain of renal colic begins quite suddenly as a rule; it may follow a strain or a fall. The pain is situated in the flank of the affected side, and is often reflected to the testicle of the same side, with retraction of that gland; or it may be reflected to the thigh. It is agonizing in character, and is often so severe as to bring on symptoms of collapse, nausea and vomiting often being present. The urine at this time may often contain some blood, and urination is frequent and sometimes painful. Occasionally during an attack of colic there may be complete suppression of urine followed by the symptoms of uremia. The length and severity of the attack depends upon the time the stone is engaged in the ureter and the size and consistency of the stone. In many cases of stone in the kidney there are no symptoms of colic, nevertheless the condition makes its presence known by a well-marked series of symptoms. Pain is one of the most marked symptoms of nephrolithiasis, usually more of a deep seated character than an acute pain, and as Morris has so characteristically brought out, is situated in the affected loin, and is not reflected to the sound kidney; it is increased by exercise and relieved by rest. This symptom of pain increased by exercise and relieved by rest, if the urine contains blood is of much importance, and should materially assist us in making an early diagnosis, which is so essential in this condition. The pain is often reflected along the course of the genital canal, and ilio-inguinal or sciatic nerves. The prominence of this symptom in nephrolithiasis depends on the location of the stone, whether it is movable or not, whether infection is present, or again, whether the stone is rough or smooth.

The presence of blood in the urine with other characteristic symptoms is often significant; usually the hemorrhage is only microscopical in quantity and of intermittent character, often following a strain, fall, or violent exercise. The source of the blood is the mucus membrane of the pelvis or calyces. It may

occur early or late in the disease, but as a rule, late. Pyuria as a symptom differs from hematuria in this respect, in that when once it has made its appearance it remains. It is a sign that infection has taken place, and as a rule after it appears, all the symptoms are exaggerated. If urine that has constantly contained blood or pus clears up, the natural supposition is that the ureter of the affected side is blocked up, and this can be definitely demonstrated by a cystoscopic examination. The passage of fragments of stone is usually absent, but when present it is quite significant of nephrolithiasis. In some cases the bladder symptoms are so prominent as to point to a calculus in that organ, but we must remember when these symptoms are present and are due to a stone in the kidney that they pass off at night and are relieved by the recumbent posture; and if they do not do this, the chances are that we have a renal tuberculosis with extension to the bladder, and not a renal concretion. Gastro-intestinal symptoms are common with nephrolithiasis and in some attacks of renal colic are so prominent as to obscure the origin of the trouble.

Nervous and mental symptoms are not unfrequently associated with stone in the kidney. Anuria from calculus is a symptom of much importance, but fortunately it is rarely seen. Unless hydro- or pyonephrosis is present, no tumor is found on palpation; tenderness on deep palpation is, however, present, and is a valuable sign. A stabbing pain over the affected side on deep percussion is considered very significant by Lloyd. In some cases where the stone is quite large and the patient is thin it is said to be possible to detect it by palpation, or if many stones are present crepitus may be obtained. A tumor developing in the loin after an attack of colic and slowly disappearing points strongly to a hydro- or a pyonephrosis. In the hands of an expert a stone in the pelvis or ureter can be detected by means of the Kelly wax pointed urethral catheter by the discovery of scratches or indentations on the wax under a magnifying glass.

It is a much disputed point as to the value of the X-ray in detecting renal calculi. Of course all depends on the experience in reading the shadow, the coil that is used, and the skill with which the exposure is made. Carl Beck in his work

on "Roentgen Ray Diagnosis" says the characteristics of a reliable skiagraph are that it shows the outline of the psoas muscle, the lower ribs and the structure of the transverse vertebral processes, and if these are well defined a calculus that is not smaller than a pea will of necessity leave its shadow on the plate. Morris in his book on "Renal Surgery" says: "In time possibly the X-ray will be able to render more assistance than heretofore, but if it demonstrates with certainty the presence of a calculus without being able also to reveal the other morbid conditions remediable by operation which mimic calculus, it will, I fear, be the means of putting back renal surgery by deterring many patients from submitting to surgical explorations, who can be cured by no other treatment than an operation." While the X-ray should be used in every case of suspected calculus, yet we must not give it precedence over clinical findings; if the clinical features are prominent and the X-ray gives a negative result, even then an exploration of the organ should be carried out.

As to differential diagnosis, the condition that most often resembles renal calculus is renal tuberculosis. In renal tuberculosis we have not only an increase in the amount of urine excreted, but there is a frequency of urination that occurs in the night as well as in the day. Very often a tuberculous family history can be obtained, and these may be associated with tubercular infection of other genital organs or elsewhere. After this disease has lasted for a while we have a descending infection of the bladder, which may be seen by the cystoscope, also in tubercular disease there is usually a mixed infection, with a large amount of thick pus in the urine associated with hectic symptoms. Again, in tuberculosis there is a large amount of blood present with sometimes blood casts, and in those cases in which the tubercle bacillus can be detected in the urine the diagnosis is positive.

Appendicitis is another condition that can be easily mistaken for nephrolithiasis unless the symptoms are carefully studied. In appendicitis there is no pus or blood in the urine, the pain begins in the epigastrium and locates itself at McBurney's point. There is often a rise of temperature, and in some cases the for-

mation of a tumor. Tumors of the bladder near to and partially obstructing the urethral orifice cause symptoms similar to renal calculus, but with the aid of the cystoscope a correct diagnosis should be made.

*Treatment.*—As soon as we are reasonably sure of our diagnosis an immediate operation should be advised. When a stone is once formed in the kidney, more or less destruction of that organ is bound to occur, and if we wait until infection has taken place and the possible formation of a hydro- or a pyonephrosis, we subject the patient to a much greater operative risk, and at the same time offer but little hope of saving this important organ. The operation for relief of stone in the kidney has but a slight mortality. Morris in thirty-four cases had only one death, and certainly no operation in surgery gives more relief from the symptoms present. In carrying out this operation, the patient is placed on the sound side, a sand bag, rubber balloon, or a specially constructed table is used to widen out the space between the lower ribs and the ilium. The incision begins half an inch below the twelfth rib, and at the border of the erector spinæ muscle and is carried in an oblique direction downwards to within an inch above the anterior iliac spine. In most cases this will give you free access to the organ; but if more room is required we can very easily make upward from the oblique incision a short vertical or slightly curved one, and by nicking slightly the outer border of the quadratus lumborum we can have a much freer exposure of the gland. After opening the transverse fascia the colon should be pushed aside to avoid injuring it, and then the fatty capsule is detached from the kidney with the fingers. It is best, however, to palpate the pelvis carefully before too much manipulation of the organ is carried out, in order to detect any small culculi that may be present, and at the same time to prevent them from dropping into the ureter.

After the kidney is freed from all attachments, it should be brought up to the surface; in some few cases, however, this is impossible, and when this is the case, the wound must be made sufficiently large to afford thorough inspection of the gland. If a stone cannot be detected by palpation, then with an assistant causing compression of the pedicle, the organ is incised along

the convex border from pole to pole until the calyces are reached, and then with the index finger these are carefully searched for stone. If no stone is found, a catheter is carefully introduced either through the convex border or through an incision made into the pelvis, and the ureter is carefully examined from end to end. If a stone or stones can be found, removal with forceps or a scoop is the next step, being careful not to leave behind a fragment or a small concretion. The opening in the pelvis if made is closed by Lambert's sutures of small catgut or silk. The incised kidney is best closed by a row of deep mattress sutures of catgut followed by separate suturing of the capsule with very fine gut. The operation is completed by placing a drainage tube down to the kidney and closing the wound around it with through and through sutures of silk-worm gut.

Nephrectomy will rarely if ever be necessary if an early diagnosis followed by operation is carried out, and in most cases even of a large cystic kidney, it is better to do first a nephrotomy, hoping that some of the secreting structure may be saved, and afterwards, if found necessary, a nephrectomy may be carried out.

BIBLIOGRAPHY: Morris, "Renal Surgery;" Treves, "Operative Surgery;" Douglas, "Abdominal Diagnosis;" White and Martin, "Genito-Urinary Dis.;" Kelly, "American Year-Book of Surgery;" Beck, "X-Ray in Diagnosis."

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## PRARAOH'S CURSE—THE PLAGUE OF FLIES.\*

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BY C. P. MCNABB, M. D., OF KNOXVILLE, TENN.

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The common house fly, *Musca domestica* of the order of diptera, of which more than twenty thousand species have been tabulated, have roamed at their own sweet will over the face of the earth, in every clime where there were men and horses, feeding on, and breeding in the excrement of both, whence they carried on their hairy feet and legs countless millions of the

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\* President's Address, delivered at annual meeting of East Tennessee Medical Society, Sept. 22, 1904.

colon, typhoid, and dysenteric bacillus, and many other bacteria, too numerous to mention.

“The fly has a sucking proboscis, two veined membranous wings, two compound eyes, which have more than four thousand facets, each facet the cornea of a separate ocellus. The spiracles through which air enters the trachea, are provided with a sieve, formed by minute interlaced fibres, which prevent dust and other foreign matter from entering. The proboscis is a fleshy, tongue-like organ or labium, which when at rest lies underneath the head. Its enlarged end may be extended into two broad, fan-like suckers, through which the fly laps up liquid sweets, like sugar, which it dissolves with its own saliva. These leaves are supported on a framework from the trachea, which end in projecting hairs, acting as a rasp on delicate surfaces, and produce a tickling sensation on the skin of man and animals. The last joint of the tarsus has two strong hooks, and a pair of membranous expansions, covered with hairs, each having a minute disc at its extremity, and it is thought to be by this mechanical arrangement that flies are capable of walking over a perpendicular pane of glass, and over smooth surfaces, back downward.”

It is not positively known how they stick on the pane of glass, but they do it, flying, creeping, crawling into and over everything, touching nothing but to defile it, a scavenger devouring both animal and vegetable matter, only requiring that it be putrid with decay, and thus, reeking in filth, they hasten to the nearest dwelling and scatter their accumulated germs of disease and filth over food, cooking and drinking vessels, furniture and carpets, bedding and clothing, doors, windows, floors, walls, and ceiling; and over the hair, hands, and faces of the inhabitants, and are not loath to journey across the lips and into the mouth of an unconscious sleeper — verily a curse well calculated to bring a haughty Egyptian Pharaoh to a realization of his wickedness, and had he fully comprehended the frightful results of the plague of flies to his day and generation, as well as to posterity, one can easily believe that he would have repented in sack-cloth and ashes, and forsooth, have turned from the evil of his ways.

So far as I have been able to learn, the written history of

the fly begins with Pharaoh's curse. It is written in the book of Exodus that the Lord warned Pharaoh that he would send a plague of flies upon the land, and also that he would sever the land of Goshen, wherein the Israelites dwelt, that no flies should annoy them, but Pharaoh heeded not the warning. "Then there came a grievous swarm of flies into the house of Pharaoh, and into his servant's houses, and into all the land of Egypt, and the land was corrupted by the swarm of flies."

Thus, as a curse from the Almighty, opens their history, and I search in vain through literature for a line of approval or word in their behalf.

I have many times, in my professional life, attended patients for anxious days and weary nights, and have at last seen the tide turn, hope return, and joy replace the gloom and dread that had hung like a pall over the home, and a few days of satisfactory convalescence pass, only to be broken by the invasion of an acute infectious disease, too often ending in death, and I have been content to call it a complication, *i. e.*, a part and parcel of the original disease coming on, because of some fancied error of diet, or nursing, the bursting into flame of some smouldering embers of the former disease, not quite eradicated by the previous attack. Then I have spent hours looking backward and looking inward, wondering if anything I had done or left undone had brought such disastrous consequences, and I now wonder if, in many of these cases, some fly did not quietly creep over the lips of the sleeping patient, tickling enough to cause the tongue to sweep out and over the lips, carrying into the mouth the leavings of those hairy feet and legs, fresh from some reeking cesspool, and thus loaded with the very essence of death, and in the frail condition of the poor convalescent, there was not sufficient resistance to do successful battle with the new invasion — hence the grim monster claimed another victim.

I doubt not that every one of you have had similar experiences, and if it be true that flies really did carry the fresh infection, how pitiable it is, that in our ignorance of the power for evil the ubiquitous fly possesses, we let the lives of patients



slip away from earth to that bourne whence no traveler hath returned.

That the fly is a carrier of disease, is fully demonstrated and freely acknowledged by authorities, and I cannot rid myself of the suspicion that it is more than a carrier of disease, and this suspicion grows as I learn more and more of the specific infections. Victor C. Vaughn and others have demonstrated to their own satisfaction (and they show reasons for the faith that is in them) that the common colon bacillus is a definite chemical compound, containing a nuclein group, an amido group, a diamido group, a mono-amido group, a toxic group, a hemolytic group, a hemoglobin splitting group, and a carbo-hydrate group, and there are possibly other groups and sub-groups of poisons yet undiscovered, and it is also believed that the colon molecule is broken up in the body by coming within the chemic influence of the body cells, and that a true chemical union takes place between certain of the body cells and one or the other of the colon bacillus toxic groups, and thus is produced definite pathological phenomena. Is it not probable also that a chemism takes place within the fly whereby the common colon bacillus acquires a toxicity which imparts to it the power to produce typhoid fever? In support of such a theory stands in bold relief the fact that an encampment of soldiers who have been selected from the standpoint of best physical adaptability, and who have not, so far as known, been exposed in any way to typhoid fever, may stay in an isolated camp for several weeks longer than the supposed incubative period of typhoid, and without a case anywhere in the neighborhood, and just as sure as there are horses about, in the manure of which flies can breed, there will soon appear an outbreak of typhoid fever, often of alarming proportions, and of frightful mortality, and too often the sanitary officers stop at the "water supply" and the "open latrine" and thus miss the real source of infection. It is, in my opinion, highly probable that the piles of horse manure literally working with the larvæ of *musca domestica*, are really more dangerous than the water supply, and it is through the full grown flies thus produced that the open latrine becomes so dreadful.

However, this is only a nebulous theory, and I doubt if I have the right to tax your time and patience with mere theorizing. Not being a biologist, I cannot make the necessary experiments to prove or disprove it. Yet I intend to bring this idea before those who are competent to investigate it, and confidently believe that it will, at least, add something to the sum total of medical knowledge. If we can agree that the fly is no more than a carrier of contagion, we will also agree that he is a most dangerous enemy to humanity and should be promptly outlawed, and thus banished from our homes, our butcher stalls, our grocers' stores, our milk-man's pans, from our barns and privies and pig-sties, and from everywhere under the sun. But how are we to do it? Let us consider for a few moments, first, that flies breed almost exclusively in horse manure, and to only a slight extent in human excrement; second, that ten days constitute a generation of flies in the summer-time; third, that an adult fly will produce about 120 eggs; fourth, that 1200 to 1500 flies will issue from one pound of horse manure; and fifth, that the number of flies will be limited only by the breeding opportunities, and the solution of the problem becomes less difficult. It resolves itself into two propositions: First, proper care of excreta; second, destruction of flies.

The scrupulous care of the stable offal and its protection from flies can be accomplished if the horse stalls are cleaned daily, and the manure put out into a pit or bin, and screened so close that flies cannot enter at all, and a little unslaked, or water-slaked lime added to it, to destroy any pupa that may be deposited before it reaches the pit. It should be remarked that air-slaked lime is worthless for this purpose, and if dry lime is used, it should be kept in a dry vessel until ready for use. Such procedure, if carried out to the letter by every one owning and caring for horses, would exterminate the house fly in not more than two or three years, and though it adds some extra labor and a small additional expense, it would repay it a thousand times in health and money spent to regain health, to say nothing of the pain and sorrow it would save to humanity.

Disposal of human excrement is one of the greatest problems of the age. In cities with a good sewage system, the inhabi-

tants are comparatively safe from its dangers, but the pollution of streams or lakes of water with sewage, is bad in principle and worse in practice, and a cheap and efficient device for sterilizing the contents of closets before it is emptied into the sewer is a great desideratum, would enrich the inventor in a very short time, and clothe him in imperishable renown forever. If a city's sewage could all be collected in a large vat, and subjected to intense heat, it could then be disposed of in any convenient way without being dangerous to health. It is not the urban, but the suburban and country places that breed the greatest dangers. The open privy vault and the cesspool "are a condition and not a theory that confronts us," and if this meeting serves to awaken your interest sufficiently to cause you to explain to your patrons the danger that lurks about their homes every summer from these sources, it will prove a blessing to the people, and a credit to the medical profession of East Tennessee. A water-tight shallow pit should be under each privy, and it should be built so close and tight that flies cannot get into it. This can be accomplished by screen lids to cover the openings, and a lid or screen should be fitted so that the pit can be cleaned as often as necessary.

After each occupancy of the privy, quicklime or dry earth ought to be poured in to thoroughly cover the discharge, and it will absorb the fluid portion and desiccate the solids so that they are made harmless. Sand is not an absorbent, and is unfit for this use. Dry fine dirt, such as collects under buildings, is probably the best. The "earth closet" is, I believe, considered by sanitarians to be the best method of disposing of human excreta in places not supplied with a sewer system, and, as I have quoted Moses (Ex. 8:21) as the first historian of the fly, I will also quote him as recommending to his people the principle of the earth closet, to wit; in Deuteronomy 23:12, 13: "Thou shalt have a place also without the camp, whither thou shalt go forth abroad, and thou shalt have a paddle among the weapons, and it shall be, when thou sittest down abroad, thou shalt dig therewith and shalt turn back and cover that which cometh from thee."

Thus with the Pentateuch there rolls down the centuries in

chaste and simple language, the very essence of modern sanitary teaching, and from the same source we learn that the swarms of flies *corrupted* the land of Egypt, and, strange to say, to this day almost nothing is done to exterminate this dangerous pest.

I hardly need to say that the doors and windows of residences, business houses, grocery stores, and everywhere that foods are kept, should be thoroughly screened. The flies that get into a house can be caught with sticky paper, and burned; or a few dishes of infusion of green tea, well sweetened, can be placed about the house, and it will be eagerly tasted by flies and is said to be promptly fatal to them.

REFERENCES: Exodus 8:21; Deuteronomy 23:12, 13; Appleton's Encyclopedia; British Encyclopedia; Bulletins from U. S. Department of Agriculture and Experiment Stations.

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## THE CUTANEOUS MANIFESTATIONS OF ACQUIRED SYPHILIS.\*

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BY J. M. KING, M. D., OF NASHVILLE, TENN.

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Syphilitic virus enters the system in many well-known ways, ten to twenty per cent. being extragenital. After inoculation the virus, or the toxin, invades the entire system through the lymphatic channels, its transmission being marked by the enlargement of the glands to the size of a pea or small nut. The glands are hard, indolent, discrete, and painless, with no tendency to suppurate. These glandular changes reach their greatest development about six or eight weeks after inoculation and persist usually through the early stages, and are not a part of the late stages except when caused by ulceration with suppuration. The virus in its invasion causes various symptoms, such as pain about some of the joints, severe persistent headache, neuralgia, bone pains, loss of weight, an unhealthy-looking skin tint, febrile action with languid feeling. The blood shows slight increase in white, decrease in red cells with diminution of hemoglobin per cent. This condition may persist for days or weeks, or until

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the eruption occurs, or until active treatment is begun. However, some cases may be free from these prodromata and the eruption will be the first sign of constitutional syphilis. In other cases, especially married women, the initial lesion being overlooked, and the early symptoms too mild to cause any disturbance, the late syphilids may be the first manifestations. As a rule the early symptoms are severe enough to demand medical advice.

In order to appreciate fully the characteristic appearance and feel of the syphilids, as to induration, atrophy, color, etc., with respect to diagnosis, a review of the histology of the lesions should be made.

A granuloma is formed in the corium by an infiltration of plasma cells, which usually arrange themselves in rows between the newly formed bundles of collagen, thus giving induration, firmness, density to the papule and tubercle.

The granuloma is very vascular and the vessels show marked proliferative changes, the small arteries being chiefly involved and there is some edema present. The coppery, raw-ham color of the syphilids results from these marked vascular changes.

The increased blood supply in the early lesions causes a proliferation of the epidermic cells, and this condition later is followed by an imperfect cornification and a production of scales.

In the late stages foci of plasma cells become encapsulated, the intercellular collagen undergoes colloid degeneration, the cells break up, and a gumma is produced.

Malcolm Morris states that all early syphilids are caused by an angio-neurotic process.

The above facts practically account for the peculiar color, induration, atrophy, scaling, and ulceration of the syphilids.

The macular eruption is usually the earliest and most common of the early syphilids, appearing about six or eight weeks after inoculation. Its distribution is general, being most abundant, as a rule, on the neck, sides of the trunk, and axillary folds, the umbilical region, and the flexures of the arms. The palms and soles are usually attacked, but the face (except sometimes the corners of the mouth and naso-labial fold), and dorsal surfaces of the hands and feet usually escape. The eruption may appear slowly, or at once; a hot bath, excitement, or exercise

often being the exciting factor, and is often preceded and accompanied by fever.

The eruption consists of small or large macules about the size of a pea or bean, rounded or irregularly shaped, the color varying from a pale pink or dull red at first to a yellowish or coppery red later, and being partly an infiltration does not entirely disappear upon pressure. Usually there is no itching.

The macules may be very profuse, but rarely coalesce; often they are faint and are only brought out by exposing the surface for a few minutes.

In some cases the macules show a tendency to papular development, forming maculo-papules, especially on the palms and soles and about the genitalia or anus, and in the latter situations becoming well developed papules, which may become macerated and moist. In five cases out of six papules will accompany the macules. (Bassercau.)

After an existence of one to several weeks, the eruption gradually or somewhat rapidly disappears, usually without desquamation, although slight scaling may show on the maculo-papules, and a slight brownish-yellow stain may remain for some weeks or longer. Occasionally there may be a slight recurrence. Syphilis, in its cutaneous manifestations, imitates nearly every disease of the skin.

The macular eruption with the concomitant symptoms, situation of eruption, and probably still the presence of the chancre and the absence of subjective symptoms, will usually lead to a correct diagnosis. It is to be distinguished from measles, German measles, tinea versicolor, and some drug eruptions. Measles is differentiated by its catarrhal symptoms, fever, situation of first lesions and crescentic and blotchy character of the eruption. In German measles the macules are small, roundish, confluent, pink or red, of short duration, with no tendency to pigmentation, accompanied by an enlargement of the cervical glands only. The drug rashes are much more vivid red or scarlet, and are usually itchy and of short duration. A microscopic examination showing the fungus will differentiate tinea versicolor.

A large macular pigmentary syphilid was first described by Hardy in 1853 and afterwards by Fournier in 1873. There is

much dispute as to whether it is a syphilid *sui generis*, or a stain following an evanescent macular syphilid. It is most often found on the neck in women of the brunette type. It is of little importance

The *papular* syphilids can be most conveniently considered under three heads: *The miliary papular*, the *flat papular*, and the *papulo-squamous syphilid*.

The *miliary papular syphilid* is very rare, not nearly so frequent as the flat papular, and usually occurs about the third or fourth month and may follow or be apparently independent of a macular eruption. The papules may be acuminate, or slightly rounded, pinhead size or a little larger, and, in contradistinction to the flat papule, they are connected with the hair follicles. They have a tendency to form in groups. At first they are pinkish-red color, later becoming dull or ham-red color with a violaceous tinge, and are dense, slightly rough to the touch, and the larger lesions may be umbilicated. It is common to see many of the papules become pustules.

This syphilid is more chronic in its course, often persisting for months, and yields slowly to treatment.

It must be distinguished from keratosis pilaris, psoriasis punctata, pityriasis rubra pilaris, papular eczema, lichen planus, and lichen scrofulosus

KERATOSIS PILARIS is most commonly found on the outer antero-lateral and postero-lateral aspects of the thigh and arms, and is often limited to those regions; there is no tendency to grouping. It is itchy, of long duration when advice is sought, and it has but slight tendency to spontaneous recovery.

PSORIASIS PUNCTATA in its early form resembles this syphilid, but it is not follicular, not grouped, not pustular, but always scaly, and while it may be general, it will be most pronounced on the sites of election — the extensor surfaces of arms and legs.

PITYRIASIS RUBRA PILARIS is a very scaly, papular, follicular disease, chronic, with tendency to confluence and persistent spreading, and no pustulation.

PAPULAR ECZEMA is very itchy, usually limited to solid confluent patches, has a vivid red color, and vesicles are often present.



In some cases it strongly resembles *lichen planus*, but *lichen planus* is rarely generalized, being found on its favorite situations, the forearms and the lower parts of the legs, to which it is often limited; it has a peculiar lilac color, is slowly progressive, and is usually very itchy.

It is identically like the rash of *lichen scrofulosus*, but the latter is rare after puberty and never later than thirty, is chronic in character, and is commonly associated with the scrofulous diathesis.

The *flat papular eruption* is one of the common early syphilids, often following closely upon or mixed with the macular lesion three or four months after inoculation. However, it may be a relapsing form of a late period. As a rule, it develops rapidly.

There are two varieties, *small flat papular* and *large flat papular*, the former being about the size of a small pea, the latter about the size of the little finger nail with rounded or oval shape. They may be widely distributed, face, scalp, trunk, and limbs, and very numerous, but are not closely packed and there is no tendency to coalescence; or they may be few and localized, but never grouped except around the mouth and genitals. Their favorite sites are the forehead, lower part of the face, nape, back of the trunk, the flexor aspects of the limbs, and about the genito-anal passages of both sexes. The lesions are distinctly elevated above the surface on account of the hyperplasia and infiltration, flatly convex, sharply defined, their color being, as a rule, deep red or raw ham tint; they are smooth, firm, dense to touch, but later there may be scaling. There may be an admixture of the macules, miliary papules, flat papules, and a few pustules all in one case.

While the papules, generally, are as above described, exceptionally, ring-like patches — the annular syphilid — may develop about the mouth, forehead, and neck. This lesion consists of a distinctly elevated, solid ridge around a flattened central area, and is most common in the negro.

In most cases after an existence of several weeks or a few months the papules begin to decline by absorption, leaving a slight pigmentation, while in other cases of the flat papular syphilid scaling occurs, sometimes early and again late, forming



the papulo-squamous syphilid. The papules become less elevated and are covered with dry, dirty, gray, adherent scales.

There is but little difficulty in the diagnosis of the ordinary scaleless flat papular syphilid. The general distribution, color, shape, firmness to the touch are characteristic, and since it is an early eruption usually other symptoms will accompany it.

The papulo-squamous syphilid probably bears the closest resemblance to Psoriasis. Psoriasis shows preference for the extensor surfaces, it is usually more scaly, and the scales are more shining and silvery in appearance, there is no infiltration and elevation, the color is a brighter red, and by removing the scales the oozing of blood is produced.

The papules, macules, and tubercles invade even the palms and soles, and on account of the thickness of the epidermis on these regions there is a considerable modification of their appearance, resulting in the so-called palmar and plantar lesions, and the lesions here are usually accompanied by the early lesions on other parts, but it sometimes occurs at a later period.

There is not as much elevation, but distinct infiltration and induration are present. At first there is no difference in the contour of the lesions here and on other parts, but later, on account of coalescence, the lesions may be irregular, crescentic, segmental, and serpiginous. The serpiginous is rather a later syphilid and more often accompanies the tubercular lesions. The color at first is a brownish yellow or red, later the scales collect and it becomes a dirty gray, but when deprived of this thick covering the lesions have the usual brownish-red or ham color. When the actual scaling begins the epidermis of the central portion of the lesion may pass off or some of it may remain adherent; but in either case the lesion will be surrounded by a collarette of epidermis, firmly attached, with the loose border pointing toward the center of the lesion, and the dark red color will show through the uncovered portion. It may be on palms and soles, and symmetrical or asymmetrical.

The appearance of the lesion following the tubercular syphilid is about the same, except that the conditions are slightly aggravated, and there is more probability of cracking and ulceration and pain.

The diagnosis of this lesion when the eruption is limited to the palms and soles, is a matter of great difficulty. It must be distinguished from Psoriasis, Eczema Seborrhœicum, and Eczema.

Psoriasis is very rarely limited to these regions.

Eczema is usually more inflammatory, the fingers and backs of the hands are more involved, and there is heat and itching. There may be the eczematous discharge or a history of such; there is no tendency to crescentic, or serpiginous forms.

It is more difficult to differentiate Eczema Seborrhœicum, but this is very rarely limited to these regions. It usually presents itself on some of its favorite situations, as the scalp, the sternal, the inter-scapular regions, etc. Eczema Seborrhœicum has a slight tendency to crescentic and serpiginous forms, but it does not present the infiltration and the color of syphilis.

*The moist papules* are papules of the ordinary type modified by the moisture and heat of the contiguous surfaces upon which they are situated. They hypertrophy into condylomata, and the hypertrophy may be more extensive, resulting in irregular warty growths called the vegetating syphilids.

*The mucous patches* are regarded as flat abraded papules on mucous surfaces, their characteristic appearance being well known.

*The vesicular syphilid* is exceedingly rare, its existence being questioned by some, but other reliable clinicians have observed it. The lesions are early, may be minute, eczematoïd, discrete, and grouped; or larger, irregularly scattered, varicella-like, and in other cases somewhat grouped like herpes. The vesicle has the characteristic papular base, the vesicular or pustular cap drying leaving a small pigmented papule.

The solid papular base, its slow evolution, its duration and sluggish character would enable one to differentiate the lesion from vesicular eczema and varicella.

*The pustular syphilids* are less frequent than the papular forms and are most often found in individuals of a depraved condition of the general health, and it may indicate a severe type of syphilis. It is best to examine the four varieties separately.

*The small acuminate pustular syphilid* is not a very uncom-

mon form of the pustular lesions, and is about the size of a pin head or slightly larger, and is usually connected with the hair follicle. In considering the origin and relation of this lesion, it seems most probable that it arises from a pus infection of the ordinary miliary papular lesion with which it agrees in point of time of occurrence and the same may be said of the other varieties of the pustular lesions, their names depending upon the predominant lesion on the surface.

The lesion has this appearance. At first it has a characteristic base, solid, dusky red, papular, which continues as such with some, in others it is transformed into a part of the pustule, and a slight umbilication is observed in some. It may appear rapidly or slowly without general or subjective symptoms.

The surface may present an association of a variety of lesions, such as macules, follicular papules and pustules, flat papules, and flat pustules. The pustules dry into crusts, and fall off, leaving a slight pit or stain surrounded by a collarette of epidermis.

The characteristic appearance of this lesion and the concomitant symptoms will seldom permit an error in diagnosis.

The *larger acuminated syphilid* is usually general, occurring in the first three or six months of the disease, and consists of pear-sized, disseminated or irregularly grouped, acuminated or rounded pustules, resembling the lesions of acne and variola. At first all are usually seated upon a papular base, which early is pinkish red, but soon takes on the characteristic color, however. Some lesions may be vesico-pustular in their formation, and rapidly become pustular. There is umbilication and in some cases it is so general that it closely resembles variola. It disappears in much the same manner as the small pustular syphilid. It is possible that this lesion might be confused with acne, variola, and iodid eruption. Acne should be rather easily eliminated.

A rapidly appearing eruption of this type with fever and malaise might present some difficulty in diagnosis from variola. But while the syphilid may be general in distribution, variola is more profuse on the face, backs of the hands and wrists; the syphilid may be pustular from the start, or first papular and the papules projecting, while the variola lesion is a deep-seated, scarcely projecting, shotlike feeling papule which changes into

a deep-seated vesicle with umbilication and later into a pustule; the syphilid usually retains its firm papular base, while variola is usually all pustular; the lesions of syphilis may be found in all stages of development, while all those of variola are nearer one stage. Considering the febrile symptoms of the two and the concomitant symptoms of syphilis, one should not fail in diagnosis.

Iodide acne is rarely profuse, more commonly on the favorite sites of acne, and there will be a history of iodide administration.

The *small, flat, pustular syphilid* is not so frequent. Its lesions are flat, discrete, sometimes irregularly grouped from a quarter to half an inch sized pustules, and occur within the first six or eight months of the early period. It is most profuse about the face, mouth, scalp, and genitalia, with a tendency to coalescence, and is associated with macules or papules on other parts. The crusts are brownish yellow or greenish hue, thick, uneven, not quite covering the base, frequently leaving a slight ulcerative or infiltrated ham-colored areola, or the crusts may extend beyond the lesion proper. The ulceration is rarely deep.

Pustular eczema and impetigo are to be excluded in diagnosis. Eczema is not ulcerative; the pustular syphilid is more generally distributed, and the concomitant symptoms will be present. Eczema is itchy. The same points should be considered in impetigo.

The *large superficial flat pustular syphilid* is similar to the small flat variety, except that the lesions are finger-nail size and larger. A deep-seated variety is less common; the crusts are darker colored and thicker, often taking on the rupial shape. The ulcers beneath the crusts are deep, rounded, or irregularly shaped, and discharge a greenish yellow, puriform secretion. These lesions are rarely profuse, the shoulders, back, and extremities being their favorite sites; the rupial form is most often developed on the face and arms. The site of the lesions is marked by scarring and brownish pigmentation, the latter disappearing very slowly. Ecthyma is the only disease to be considered in diagnosis. The single lesion of ecthyma is inflammatory with an extensive, hard, and bright red base, and areola, while the syphilitic lesions are sluggish, more numerous, and are

attended with deeper and more sharply cut ulceration with thicker crusted and are followed by scarring.

The *tubercular syphilid* may exceptionally occur within the first year as a more or less generalized eruption, possessing the same characteristics as the papules except as to shape, but usually it is a late secondary or tertiary lesion, appearing several years after inoculation, limited in extent to one or several regions and occurring in segmental, circinate, and serpiginous groups. The tubercles possess the same characteristics in both early and late stages, having a smooth, glistening surface, or covered with thin scales. They are rounded or acuminate in shape, of a brownish red or coppery color, the size of a small pea, extending into the corium and sometimes deeper. In some cases the tubercles disappear by exfoliation and absorption, leaving pigmentation with probably slight atrophy, but in the majority of cases they undergo ulceration. In the latter cases there are found tubercles, ulcers, and crusting, and the ulcers may be small, discrete, and punched out, or of the segmental, crescentic, or serpiginous type. Clinically, this lesion may closely resemble *lupus vulgaris*; the favorite site for lupus is the face, while the tubercular syphilid occurs almost on any part, and the face is quite a frequent seat. Lupus usually occurs early in life, the tubercular syphilid late. The color of lupus is of a yellowish or a brownish red; that of the tubercular syphilid being a darker red. Lupus is slow in its progress; the syphilid is more rapid. The peculiar configuration which often occurs in syphilis is seldom seen in lupus.

The discharge in lupus is scant, while it is usually profuse in syphilitic ulcers. Lupus rarely attacks bone; syphilis more often does. The lupus scar is often thick, dense, and tough, while the syphilitic is soft, atrophic, and velvety. Confusion may sometimes arise with epithelioma, acne rosacea, leprosy, sycosis, psoriasis, and ring-worm.

The *gummatous syphilid* is usually a late tertiary formation, but it may occur in the early stage in precocious cases. It presents itself usually as one, or several, painless or slightly painful, rounded or flattened, circumscribed tumors slightly projecting, having their seat in the subcutaneous tissue. At first it

can be felt as a pea-sized deposit which may reach the size of a walnut or much larger in a few weeks. It may disappear by absorption or break down into a deep, punched out ulcer, with a free gummy secretion. In other cases the gummatous infiltration is more diffuse, involving an area the size of the palm without sharply defined edges, and this area may ulcerate in patches, or as a whole, with the ordinary discharge. The favorite sites for the gummatous syphilids are the soft parts, the thigh and calf region and the trunk, but may occur on any part of the body. The gummatous process is very destructive, involving bone as well as the soft parts and often producing much deformity.

The diagnosis of gumma in the earliest stages is sometimes difficult, since there is a resemblance to furuncle, abscess, enlarged lymphatic glands, sebaceous, fatty, and fibroid tumors, and to erythema induration. The ulcers may have to be distinguished from epithelioma. Many cases of erythema induration have been treated for syphilis, and gummata have been removed with the knife by mistake.

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## EXAMINATION QUESTIONS IN PRACTICE OF MEDICINE.

AT THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF  
THE SOUTH, SESSION OF 1904, SEWANEE, TENN.

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ANSWERS BY WM. J. SCHMIDT, OF NEW ORLEANS, LA.

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1. Differentiate between Gastric Ulcer, Gastric Carcinoma, and Gastralgia, and give treatment for Gastric Ulcer and Gastric Carcinoma.—*Prof. Roberts.*

In gastralgia hematemesis, localized pain, tenderness, and pain in back are wanting, and pain after eating not so marked, sometimes relieved. Gastralgia occurs in active period of life, often in drunkards; tumor is not present, skin is harsh and dry, pale; emaciation more marked than in ulcer, not so much so as in cancer. Usually a viscid mucus is vomited, gastric juice is

colorless. In peptic ulcer hematemesis may be a pronounced symptom, blood is bright red; that of cancer is dark, grumous, so-called coffee ground vomit. Tumor may or may not be appreciated in ulcer, is more marked in cancer. We may have emaciation in ulcer, but more marked in cancer, also characteristic cachexia and great prostration. Skin negative in ulcer, pale straw or fawn color in cancer. Ulcer most frequent in females under thirty-five, cancer rare before forty. In ulcer pain is described as burning, boring; in cancer, lancinating. In ulcer hyperacidity from excess of HCl O, which is absent in cancer, lactic acid being found (perverted acidity). Applying above to patient, inquire as to age, and if over forty suspect cancer. Sex and habit if male and an alcoholic, favor gastralgia. Occupation, as shoemaker, or any cause producing pressure over epigastrium will favor cancer. History of family may elicit factors for or against cancer. If female, suspect ulcer; and vomit if bright red, arterial, is pathognomonic of ulcer. Do not confound hemoptysis with hematemesis. The former is expectorated and may be frothy; the latter is vomited and may be mixed with particles of food. In ulcer we may have dark blood vomited but it is rare, and is frequent or constant in cancer. Appearance of patient, cachexia, rapid emaciation and exhaustion will complete the picture of carcinoma.

*Treatment of Gastric Ulcer.*—Unequivocal rest of the stomach must be enforced, using nutritive enemata as limited as the economy can subsist on, as feeding in this manner may irritate the rectum and it will refuse to absorb. The enemata should consist of milk, preferably peptonized or predigested, or with lime water added, egg albumin, meat juice, limiting the amount to two to four ounces every three or four hours. If rectum is irritated, hot saline solution to flushing followed by rest will act nicely. For collapse due to hemorrhage, strychnia hypodermatically, inhalations of ammonia, etc. The following may be used: R. Plumbi acetas, grs. xx; p. opii, grs. viii; Ft. pulv. no. 4. Sig.: One at once, followed by another in 15 minutes or more if rejected or necessary. Or we may use hypodermatically, morphia sulph., gr. 1-6th, ergotine, grs. iij, plumbi acetas, grs. ij. The liq. potas. arsenitis in doses of ij drops every five hours



has many advocates in gastric ulcer, while others use bismuth. Do not lose sight of the necessity for absolute rest of the stomach, and do not promise anything.

For cancer, therapeutic measures will not cure, and surgery offers the only hope, and that is negative. Those operators claiming to have cured cancer possibly did not have this condition to deal with, or probably their claims were made too early. Several procedures are indicated, none of which ultimately cure. (Philosophy: If you cannot cure, palliate, and opium is probably the best method. Tentatively restrict diet and relieve pain. The Germans claim benefit from cundurango as an alterative. Bismuth and creosote are used by some in this country.)

2. Give causes, symptoms, and treatment of Acute Parenchymatous Nephritis, Chronic Parenchymatous Nephritis and Chronic Interstitial Nephritis.—*Prof. Roberts.*

*Acute Parenchymatous Nephritis.* Causes: Exposure, persistent use of irritating drugs, as cantharides, ginger, turpentine, potas. chlor., in large doses. As a sequela of the exanthemata as scarlet fever, rubeola, etc., the infectious diseases, as diphtheria, typhoid fever, etc., also traumatism, pregnancy, in fact anything that interferes with the secreting structure of the kidneys.

*Symptoms.*—We have a slow developing dropsy, anæmia, dyspnoea, weakness gradual but progressive; or suddenly developing cases with fever, nausea, and persistent vomiting, dull pain in lumbar region radiating along ureters to urethral meatus, possibly a constant desire to micturate, eyelids then face swollen, edema extending to scrotum and extremities and abdominal walls. Urine scanty, high colored, looks smoky (especially after exanthemata or during eruption), high specific gravity, 1025 to 1030, albumin, epithelial, and blood casts. What is a cast? Albumin is coagulable, and in coagulating will be molded into form of vessels in which it is contained. This usually occurs in the uriniferous tubules. Why do we say "epithelial casts"? Because under catarrhal inflammatory processes there is always a great exfoliation of the epithelial cells of mucus membrane, these are entangled in the gummy albumin, and when coagulation takes place, being imbedded in the albumin, we call them



epithelial casts. This brings on another question: What significance do these casts have? In the pathology of catarrhal inflammatory processes of mucous membranes, first there is hyperemia or engorgement, then hypersection with exfoliation of epithelial cells; which means that if we have epithelial casts we necessarily have an acute affection, that being a diagnostic point; and if we have epithelial tube casts we are dealing with an acute or recent affection. If we have considerable engorgement, we find that the red corpuscles are extravasated out through the stomata of the walls of the vessels, and if these red cells are incorporated in the albumin we call them blood casts. If the cells contain neither epithelium nor blood cells, they look clear and waxy, and we call them hyaline casts, and they indicate that we have passed from an acute to a chronic condition.

In exanthemata, infectious diseases, and some pernicious malarial attacks we find kidney complications, due to the fact that the skin and kidneys are supplementary organs or emunctories, and that during any of the above conditions, the skin being unable to perform its eliminatory and exhalatory functions, this effete material must be eliminated, and the skin being unable to do its part, the kidneys try not only to increase their own work, but endeavor to do that of the skin. This double duty being too onerous, they break down, their action is perverted, and instead of eliminating urea and other waste products, they throw off the essential nutritious albumin. The poisonous effete material being retained, we have Bright's disease, or even uremia. We also find that oxalates, certain refracting crystals, urates, etc., are excreted, and urea, phosphates, and chlorides are retained or do not appear in the urine. These facts indicate certain philosophical methods of treatment. The disease being sometimes insidious, not readily appreciated, an acute attack fails to get well, and chronicity is the natural outcome. It is rarely recognized until dropsy or some other marked feature appears. The effusion first appears in the eyelids, eventually extending over the entire body. Dyspnœa may result from the ascites, and we may have cardiac palpitation, headache, defective vision, peculiar waxy or pasty color of the skin, and other features characteristic of a chronic renal condition. We find the urine

high colored, cloudy, high specific gravity, scanty, but neither epithelial or blood casts, but hyaline or waxy casts.

*Treatment* of either acute or chronic conditions resolves itself into two propositions: First, correct the elimination, and then keep the patient alive. Arouse the other emunctories, stimulate the skin and bowels to increased activity, and thus relieve the kidneys. Get rid of as much waste material as possible by purgation with magnes. sulph. or other salines or hydragogue cathartics. Warm or hot baths, hot sponging, hot air baths, aided by sudorifics and diaphoretics, from neutral mixture to pilocarpine will enable the skin to excrete a large amount of waste and effete matter. Flush out the kidneys with plenty of water, give potas. bitart., acetate, or citrate. Enforce absolute rest in bed and give iron and strychnia with other bitter tonics, with a suitable nutritious and non-nitrogenous diet, including plenty of skimmilk, or buttermilk. The following may be used: R. Hydrarg. chlor. cor., gr. ss; ferri sulph. exsic., gr. xl; acidi arseniosi, gr. ss; ext. nucis vom., gr. x; glycerito amyl, q. s.; Ms. Ft. Pil. no. 20. S.: One pill three times a day. Warm clothing, flannel next to skin, pleasant environment, and plenty of fresh air.

*Chronic Interstitial Nephritis.* The former both involved the secreting structure, while here we find the connective tissue between the parenchyma involved.

*Etiology.* Heredity, often occurring in families who have tendencies to degeneration of the walls of the arteries, etc., which would bring in rheumatism. Alcohol is often a cause. Syphilis may produce it. Constant overeating may produce it. Any functional disorder of the liver may predispose to it. Gout is an important factor in Europe, but not in this country. Lead is supposed to be a cause. The most common is arterio-sclerosis, which usually occurs in men over forty, hard workers, free eaters, and excessive alcohol drinkers, and is often secondary to chronic cardiac disease. (Remember that senile atrophy is a natural process.)

*Symptoms* are as a rule latent. Complaint of lassitude and sleeplessness, failing vision, headache, frequent micturition, especially at night. The structural changes in heart, kidneys, and

vessels are often discovered before the disease is appreciated. Pulse is hard, tension increased, and vessel walls are thickened, (tension persists on pressure) which causes hypertrophy of left ventricle, trying to overcome resistance, apex beat being displaced downward and to the left, second sound at aorta accentuated, systolic murmur at apex may be present, œdema of glottis, even effusion into plasma may occur, bronchitis and an asthmatic condition frequent. Cheyne-Stokes breathing toward end, œdema rare except in conjunctiva, rarely of ankles. Skin pale and dry, sweats occasionally, dropsy seldom occurs.

Urine is abundant, but pale colored, low specific gravity, 1005 to 1015, slight trace of albumin, occasionally hyaline casts, urine and pulse are almost pathognomonic.

*Treatment.*—Prolong life, as the disease is incurable. Treatment as given in parenchymatous is as good as any, always treating *cause*. Baths daily.

3. What is Ascites? Give causes, differential diagnosis and treatment.—*Prof. Roberts.*

*Ascites* is an abdominal dropsy, an accumulation of serous fluid in the peritoneal cavity.

*Etiology.*—Serous membranes under inflammatory processes choose one of two vices: First, exude a plastic lymph and causes surfaces to agglutinate, forming adhesions interfering with movement and causing extreme pain; secondly, excite an excessive flow from walls, a hypersecretion of serum is exhaled, amounting to pints or even quarts, and causing dropsy, or rather ascites in peritoneal cavity. A retrocession of blood from periphery to internal organs will cause engorgement and produce peritonitis and ascites. The blood, becoming hydræmic, leaks through stomata of vessels into cavity. A septic peritonitis may cause interference to portal circulation due to torpidity or occlusion, and engorged vessels may pour out serum into peritoneal cavity. Chronic torpidity of liver, also interstitial hepatitis after cell structure is squeezed out of liver or its function interfered with, will cause venous system to be dammed back, causing ascites. In atrophic condition of liver ascites always follows, as does also diarrhoea, dysentery, etc. Pleural dropsy may also

cause ascites, due to serum gravitating through pleura and diaphragm into peritoneal cavity. *Cavity dropsies* are nearly always due to inflammatory causes. In ascites you can get fluctuation. In anasarca in which the serum is under the skin we get pitting, nearly always due to kidney trouble.

*Treatment.*—Treat cause in all cases. For dropsical condition it is necessary to get rid of fluid as it is debilitating. This is best accomplished by depleting the system, in this way creating a demand for serum in the blood-vessels depending on serum endosmosing back into the vessels. First, run all the serum possible out of the bowels; hydragogue cathartics or salines, as magnesium sulphate, are best. These run the serum out of the blood in lower zone, depleting lower bowel and pelvic viscera, which causes blood to become thirsty and it tries to suck up the fluid in cavities or tissues. Second, get rid of as much as possible through action of the kidneys by using diuretics, preferably the potashes, which flush out the kidneys, increase the normal or natural method, while digitalis and other irritating diuretics accomplish same result by perverted methods. The bitartrate, acetate and citrate of potash are best. Third, induce skin to assist by using diaphoretics and sudorifics. The former induce sweating; the latter cause sweating by stimulating sudoriferous glands. Hot baths, volatile substances, as twenty per cent. solution of alcohol, ammonia, etc. Turkish and Russian baths, Dover's powders, antimony, jaborandi, etc. Elaterium should only be used on failure of above means; and as a last resort, perform paracentesis abdominalis, but do not draw off all the fluid at once, as it may cause enteritis.

Ascites differentiated from ovarian tumors: History, enlargement in iliac fossæ, and does not change position when patient lies down. Ascites does; it gravitates; tympanites at sides, and dullness on top of cyst; opposite in ascites.

Ascites differentiated from pregnancy: History, signs of pregnancy absent in ascites.

Ascites differentiated from distended bladder: History, tenderness localized in distended bladder.

Chronic peritonitis is painful, tender, has vomiting, abdominal

walls are thickened, and is associated with cancer or tuberculosis. Ascites does not agree with this.

Chronic tympanites does not give dullness, only similarity is distended abdomen.

4. Describe the lesion and localization of *Tabes Dorsalis*, and give diagnosis and treatment.—*Prof. Roberts.*

*Tabes Dorsalis* is a chronic degeneration of the posterior columns of the spinal cord, and is characterized by inco-ordination. Sensory and trophic disturbances involving special senses, as eyes, etc., occurs in adult life, rare among negroes, frequently in males, generally of syphilitic origin; other causes are accidental, as exposure, fatigue, injury, over-exertion, and excessive venery.

Lesion occurs in segments, and is a progressive and destructive process in which the post. columns of Goll and Burdach, and even fibres in Clark's column are attacked; also roots and ganglia and partly peripheral nerves as the optic. The nerve fibres are first involved. It is not a simple wasting, but is accompanied by irritation due to swelling of axis cylinders, and proliferation of connective tissue with slight congestion.

*Diagnosis.*—Early it is recognized by lightning pains, girdle pain, and absence of knee jerk, also progressive atrophy of optic nerves. The early ocular palsies are almost pathognomonic. A squint or Argyll Robertson pupil, often ptosis, history of syphilis usually present, and is a leading factor, Romberg's symptom, etc.

From peripheral neuritis, the gait differs, and in alcoholism, diabetic or arsenical paralysis, the feet are lifted high so toes will avoid floor, and the pathognomonic symptoms of tabes are absent.

From ataxic paraplegia: This is a true paralysis, and locomotor ataxia is not; neuralgic pains and eye symptoms absent.

From cerebellar disease, knee jerk is present, no lightning pains, but headache, vertigo, nausea, and vomiting are present; neuralgic pains and eye symptoms are absent.

It is difficult to differentiate from general paresis.

*Treatment.*—A man in this condition should avoid venery and other excesses, and live a regular life. Diet in all cases must be regular and nutritious; the treatment may be that of the syphilis in recent cases, both potassium iodide and bichloride of mercury

are practically useless in the cure of those cases where syphilis cannot be detected. Full doses of arsenic and small doses of silver nitrate are highly recommended. Others recommend gold, ergot, and physostigma. The suspension treatment is not much used at the present day, although good results have followed the method. Absolute rest in bed, blistering with counter irritants over area of spine, or using the thermo-cautery. Turkish baths are valuable, but nothing equals opium in relieving the pain, but it should not be used as long as you can make patient get along without it. Cocaine for the laryngeal spasms, or chloroform inhalations, nitro-glycerin when there is arterial tension in increasing doses if not contraindicated by heart lesions. Keep bladder empty, using catheter if necessary. The patient can be taught to perform simple movements.

5. Give differential diagnosis of Epilepsy, Apoplexy, Acute Alcoholism, Opium Poisoning, and Uræmic Coma.—*Prof. Roberts.*

Epilepsy, apoplexy, acute alcoholism, opium poisoning, and uræmic coma may be differentiated by the following points.

*Epilepsy.*—Convulsions precede coma, the pupils are usually dilated, patient cannot be aroused, usually bites tongue, frothing at mouth, the sudden fall, no cerebral congestion, paralysis and unconsciousness rarely last more than one half to one hour.

*Apoplexy.*—Examine for hemiplegia, cerebral congestion constant, plethoric people usually, paralysis and unconsciousness persistent, patient cannot be aroused, pronounced stertorous breathing, coma is deep, pulse slow and strong, eyes and head turned to one side.

*Acute Alcoholism.*—History of drinking, persistent odor of alcohol in breath, pupils dilated, does not bite tongue, subnormal temperature best taken in rectum, flushed face, full pulse, deep but rarely stertorous breathing, can be aroused and mutters incoherently, muscular twitchings but convulsions are rare. Inhalation of ammonia will ameliorate the condition, pressure on supra-orbital notches may cause return of consciousness.

*Opium Poisoning.*—Coma develops gradually, temperature normal, pin-hole pupils, convulsions are persistent, no frothing at mouth, pulse slow, respiration slow and quiet, patient can be aroused momentarily, no heavy stertor.

*Uremic Coma.*—Headache, dullness and apathy precede coma, twitching of muscles of face may or may not be present, pupils medium or dilated. Look for albuminous retinitis, note odor of urine, it is peculiar, examine it, history of Bright's disease, rapid rise of temperature while skin seems the same, weak regular pulse.

6. Give cause and nature of Croupous Pneumonia. (a) Structural Changes at the second stage. (b) Physical Signs at the second stage. (c) Differential Diagnostic Points between Croupous and Catarrhal Pneumonia.—*Prof. Cain.*

Croupous, lobar, or fibrinous pneumonia is a specific disease, a pneumonitis due to entrance and multiplication of the diplococcus pneumoniae (Fränkel), in which the alveoli are entirely filled with a plastic exudate which renders them impervious to air, and rarely if ever involves the interstitial tissue.

*Structural Changes During Second Stage.*—This stage is called red hepatization, and follows that symptom the rusty sputum. As the plastic, fibrinous exudate and leucocytes are poured into the alveoli, the mechanically expressed or extravasated red blood corpuscles are caught in the exudate which coagulates; this process continuing until entire alveoli are filled, and the tenacious exudate hardens into a cheesy and impervious substance forming plugs. On cutting through lung tissue at this stage it looks red, and is granular, resembling a slice of liver (hence its name). This of course attacks only a portion of lung, usually lower right lobe, and the entirely affected tissue undergoes complete solidification; this solidified tissue acts as a good conductor and elicits several well-defined physical signs, as follows: Harsh bronchial breathing, even bronchophony, vocal fremitus becomes intense, skin is hot and dry, dullness on percussion, and as the lung tissue or the parenchyma is unable to work, there is absence of normal vesicular murmur; even now you might get crepitant rales along margin of dull area, from inspissated mucous and blood extending peripherally or by metastasis. Puerile breathing in healthy lung due to compensation; it is doing more than its normal work. It might be added that blood-letting will tide over the crisis. Nature now begins to pour out serum around the plugs and we pass to resolution or third stage.



Differential diagnosis between croupous and catarrhal pneumonia:—

*Croupous*.—Initial chill, usually at night, is the beginning of fever, tongue dry, coated, rapid shallow respiration, flushed cheeks, especially on the side affected, pain in affected area, usually whole lower right lobe, respirations as high as thirty to forty per minute, usually unilateral, herpes labialis generally present. Usually runs a regular course to death or resolution, and goes off by crisis.

Generally after the third year. Generally sets in abruptly. Diagnose by well-marked physical signs.

*Catarrhal*.—Usually secondary to a bronchitis, travels into alveoli by continuity, and does not involve enough capillaries to cause a capillary bronchitis. Also has chill and hurried respiration, but pain is in spots which are scattered all over the lungs, usually bilateral; no eruption on lips, no flushed cheek, usually an irregular course, and patients gradually recover or die of pathological shock or asthenia. It usually occurs in children one year of age. Develops insidiously, often diagnosed by exclusion. No marked physical signs.

7. What is Pyrexia? (a) Hyperpyrexia? (b) Give benefits and evils which may result from each. (c) How is Pyrexia produced? (d) Mention four classes of antipyretics and tell how they act.  
—Prof. Cain.

Pyrexia is an exaggerated physiological function or condition, characterized by the body temperature going above the normal  $98.5^{\circ}$  blood heat.

Should it reach  $103^{\circ}$  or  $104^{\circ}$  we may call it hyper-pyrexia, but most authors put it at  $105^{\circ}$  or  $106^{\circ}$  according to their ideas as to where pyrexia ends and hyper-pyrexia begins.

Pyrexia is nature's method of attempting a cure in certain diseases, as for instance typhoid fever, in which nature is burning up a vast amount of waste products as tissues and toxins. Disease often produces a detritus or toxins manufactured by germs, and these products must be gotten out of the economy, so nature carries more oxygen, and combustion being increased, heat is evolved. It is essential in certain conditions, but when it goes beyond  $103^{\circ}$  and becomes hyper-pyrexia it is destroying



and burning up nerve matter, and is having a deleterious effect on blood and other tissue, and must be interfered with, as it becomes dangerous to the vital functions.

Pyrexia is due to some pathological influence stimulating the thermo-genetic center. The immediate causes, however, are increased heat production; but mainly decreased heat elimination or dissemination. Nature reduces temperature by bringing on perspiration; its evaporation absorbs latent peripheral heat and the temperature goes down. If heat is confined, and nature cannot produce diaphoresis, the temperature goes up.

*Treatment, First Method.*—Lower temperature by producing diaphoresis, stimulating sudoriferous glands, and for this purpose such therapeutical agents as syrup of ipecac, sweet spirit of nitre, etc., are used; the best and least injurious is the neutral mixture which is both sudorific and diuretic:  $\mathcal{R}$ . Citric acid, gr. 80; bicarb. of potash, gr. 70. Add a little syrup of lemon and sufficient aqua to make 8  $\mathfrak{z}$ . In some cases a drop of aconite to each dose adds to its efficiency. It may be added that previous to any of the four methods, all irritating and toxic material in bowels should be flushed out with calomel and castor oil or salts.

*Second Method.*—Lessening heart's action, paralyzing vaso-motor or stimulating vaso-inhibitory nerves. This will dilate peripheral vessels and allow maximum radiation, and latent peripheral heat will be absorbed and temperature reduced, which is best accomplished by the use of heart sedatives, as aconite, veratrum viride, and tartate of antimony. These cause blood to linger at periphery, and it cools, but this method is not only permissible in dynamic cases, and in adynamic cases where heart inertia may occur, such as diphtheria, it is contraindicated; it does not act by impairing blood, but by slowing circulation.

*Third Method.*—The use of coal-tar products, such as acetanilid, antipyrine, phenacetine, etc. These are analgesic, and prompt and reliable antipyretics, but they lower temperature by producing a chemical change in the red blood corpuscles, interfering with their oxygen carrying capacities, lessening amount of oxygen for combustion, reducing the fuel, reduces heat produced, and lessens or lowers body temperature. They are not heart sedatives as in second method.

*Fourth Method.*—The most important of all, and akin to nature's own idea. Nature gets rid of heat peripherally by perspiration, the evaporation or the conversion of the perspiration into vapor requires an immense amount of heat; this is absorbed from periphery, and is the peripheral latent heat, but this is also due to the cool air; hence when a person gets warm he sheds his clothes as much as possible, and hunts a cool place. Dr. Brandt took advantage of this fact and systematized what is called the Brandt treatment or method. Either cold blankets, cold baths and sponging, etc. Probably the best method is to put the patient in bath at temperature just below his own and add ice or cold water gradually. This abstracts heat and does not produce shock. The philosophy being the fact that the cold water absorbs the peripheral, latent heat, cooling the blood peripherally; and as circulation continues the entire blood is eventually cooled and temperature is lowered. A twenty per cent. alcoholic solution or any volatile agent will absorb latent heat in the same way, the heat being abstracted as the volatile substance flies off.

8. Give cause, nature, and treatment of Diphtheria.—*Prof. Cain.*

Diphtheria (a membrane or skin, leathery), or putrid sore throat is due to a specific germ, the Klebs-Loeffler Bacillus, which produces a toxic, potent, alkaloidal poison; a toxine or ptomaine which produces the disease; the streptococcus pyogenes is constantly found. It is a disease of childhood, and one attack rather predisposes to others. Pernicious cases are due to mixed infection. Bad hygienic surroundings seem to predispose to it, and catarrhal inflammations, especially the chronic, often devitalize the mucous membrane, putting the soil in a condition so seed when implanted easily promotes growth and multiplication of germs.

Diphtheria is an acute, specific, constitutional disease which is infectious, contagious, and inoculable, producing local manifestations of sore throat and a formation of a deep-seated membrane or pellicle.

Germs find lodgment in the fauces usually, but may lodge on any denuded surface where soil is tender. The seed becomes im-

planted and grows, multiplies rapidly, leaving certain principles capable of producing the disease. As a rule they are inhaled, and the recoil of air deposits them about the fauces. They may be carried into bronchia, œsophagus, and stomach. Alexins in secretions kill germs provided the secretion is normal, but secretions in children are not developed. The first saliva at time of teething is manufactured by irritation to gums; it is perverted and devoid of germicidal principles (alexins), and infants are overwhelmed with the toxic influence. The diphtheria germs, like the gonococcus, burrow down into the sub-mucous tissue, and after producing the toxine which overwhelms the nerve centers, produce fever, and cause a local necrotic process to take place, which, like gangrene, destroys its vitality. The membrane looks gray, smooth, and glistening; the surrounding tissue becomes engorged and membrane looks sunken. Nature ulcerates it out and leaves excavations which heal by filling with granulations, heal by cicatrization which is always a weak, tender soil for future attacks. Diphtheria is an asthenic disease, *always* causing a feeble rapid heart, but does not interfere with respiration directly. It also vitiates the blood, and hæmatic diseases often produce deleterious effects on the nerve centers.

*Treatment.*—To treat blood, sustain patient, and secure perfect elimination are the three requisites. Nature will manufacture an antitoxine which gives better results than that injected under antitoxine treatment. Locally, the treatment is negative, medicated sprays are used or the chloride compound, or painting with camel's hair brush (don't swab, as it will spread). Remember the upper coat is impervious. If seen early, paint edges with silver nitrate sol. This coagulates sub-mucous tissue, building a wall around infected area. The best method of treating a case is as follows:—

Put patient in a sunny room, give plenty of fresh air, keep emunctories aroused and bowels open; use strychnine for asthenia, and the following for constitutional and local effect: Chlorinated compound:  $\mathcal{R}$ . Hydrarg. chlor. cor., gr. 1-5; acidi hydrochlor. dil., m. xxx; tinct. ferri chlor., m. xxx; pot. chlor., gr. xxx; glycer.  $\mathfrak{z}$  j; syrapi,  $\mathfrak{z}$  j; aquæ q. s.,  $\mathfrak{z}$  iv. Ms. Sig.: One teaspoonful (for child) every twenty or thirty minutes to

get local and constitutional effect. Use strychnine for the paralysis, and look out for erysipelas and gangrene; also watch kidneys.

9. Describe Typhoid Fever up to the second week, giving symptoms and structural changes.—*Prof. Cain.*

Typhoid or enteric fever is a specific, continuous fever, characterized by prodromes, epistaxis, stupor, and constant lesions of Peyer's patches.

Prodrome is present in all typhoid fevers, characterized by malaise, sleeplessness, bad dreams, headache, etc. Typhoid bacillus getting into alimentary canal reaches intestines, and as most nutrient material is in the ileum, they stop there and burrow down into the sub-mucous tissue, and live on the lymphoid structure (lacteals), multiply and produce ptomaines which are narcotic poisons whose overpowering effect on nerve centers produces the fever. During the prodrome the ptomaines are insufficient to produce the fever, however, patient gradually gets worse.

*First Stage — Advent.*—This stage lasts seven days, and is characterized by headache, stomach may be involved, diarrhoea generally, and is preferable to constipation which is fortunately rare, step-ladder temperature, fever goes up one-half to one degree in afternoon, but drops following morning; that afternoon goes up another one-half or one degree, but drops the next morning to that of previous afternoon, etc. Headache stops about third day, bronchial cough always present, but disappears toward end of first week, epistaxis, pulse begins to weaken; it is an adynamic disease, and is spoliative, due to great molecular disintegration, pulse goes up parallel or in co-ordination with pyrexia.

Diarrhoea is preferable because it carries off a great deal of exfoliated tissue full of germs and ptomaines, and mitigates the attack to some extent. Lethargy and indifference to surroundings, do not recognize friends readily, seem too tired to talk, eat anything you give them. If symptoms above given harmonize the picture is complete; other symptoms equally pathognomonic are: sleepy eyes, cupped tongue (edges are turned up, and it is tremulous and white looking, patient is loath to pull it in, and has to be told to do so), tenderness over right iliac fossæ

and borborygmi, and about seventh day a flea-bite eruption appears about abdomen, chest, and back which may be due to disease or fleas and other insects. At seventh day temperature is at about  $104^{\circ}$ , and if it goes higher there are likely complications or septic influences at work. Hemorrhage from bowel, though rare, does occur before seventh day, due to rupture or erosion of a vessel, but it is not necessarily unfavorable. Typhoid may occur anywhere, or at any age.

*Pathology.*—As autopsies so early are rare, pathology is not as well known as later in the disease. The serum of the blood is attacked, as corpuscles show little change, ptomaines vitiate the serum, spleen and liver enlarge, stomach may be involved, as also bowels. Toward the end of week structural changes take place in the ileum, and at end of seventh day they are pronounced. Hypertrophy and proliferation of the solitary and agminate glands take place; they are swollen and rise up above surrounding tissue; intestines may become engorged below. Papillæ are prominent (termed “shady beard”), kidneys are generally impaired, also bronchi, but no structural changes can be detected in either.

10. Give general mode of treating Malarial Diseases.—*Prof. Cain.*

*Treatment of Malaria.*—For acute, always use quinine; but always arouse emunctories, as the liver is usually torpid, spleen enlarged, and intestines inactive, and there is often auto-infection. Get rid of effete material by all channels, skin, kidneys, liver, and bowels, and do not let it drop into chronicity. Use potassium bitartrate for kidneys, and for bowels the following: *R.* Massæ Hydrarg., gr. ij; hydrarg. chlor. miti, gr. j; ex. hyoscyami, gr. ss. *M. Et. ft. pil. no. j.* Give *at once*, and follow with castor oil.

If the case is inflammatory, do not use quinine until you have broken up all complications, such as gastritis and enteritis, and treat them as protean diseases. Where no complications are present begin with prescription given, and after bowels are cleaned out, start quinine. It is best given after sweating stage, three grains every two hours up to twelve or fifteen grains, no more for simple cases. Do not use it during dry stage, but repeat next day, lessening amount. Do not use prostrating doses in simple

cases, and always administer quinine the day before attack is expected. It may be necessary to repeat mercurials, but remember that both mercury and quinine linger in the economy after acute attack is broken up. For prophylaxes administer liq. potass. arsenitis three to five times daily as a tonic and anti-malarial. The liver and spleen usually go back to normal size. If it fails, give the following for the so-called ague cake, which is due to proliferation, causing enlargement of spleen, and is due to permanent presence of germs which interfere with its function: *R.* Hydrarg. chlor. cor., gr. ss; acidi arsen., gr. ss; podophyl., gr. ij; quininæ nitrat., gr. xxx. *If blood is olygæmic, add ferri sulphitis exsiccatus, gr. xxx.*

For nerve tonic a parvule of phosphorus, 1-100 of a grain, and two grains of oxide of zinc at a dose administered in capsule. Dilute hydrochloric acid is of service, and may supplement above prescription. In pernicious cases, correct elimination, establish peripheral circulation at once by warmth and friction, large doses of quinine at once, and if stomach cannot absorb, give it hyperdermatically; ulcer is preferable to death, but do not use quinine unless moisture appears. Arouse emunctories, use mercurials, if brain is engorged, bleed freely.

11. Describe Diarrhœa. (a) Give varieties. (b) Give general rule of treatment.—*Prof. Cain.*

Diarrhœa means a flowing through, and is really excessive bowel action due to some irritable condition of small (upper) intestine (lower causing dysentery). There are four varieties, stercoraceous, crapulous, choleraic, and lenteric.

*Stercoraceous* is excess of feces, due to catarrhal enteritis of small intestines. It is a hypersecretion of Lieberkühn's follicles. Give castor oil and laudanum, turpentine, lead acetate, dilute sulphuric acid, etc.

*Choleraic.*—Profuse watery discharges resembling cholera, due to cholera or cholera morbus, etc. Runs serum out of the blood, due to decayed fruits, bad water, etc., no pathological lesions. Give calomel, camphor, strychnine, and opium. Relieve liver with mercury, then camphor, opium, and gallic acid, or nitric or sulphuric acids (dilute).

*Lienteric (slippery gut).*—Food passes through without digestion. It is due to lack of volvular tonicity or interfered peristalsis. No pathology. Stop eating for a while, and give camphor, pepsin, hydrochloric acid (dilute), nux vomica, iron tinc., phosphorus, and arsenic.

*Crapulous.*—Usually due to drunkenness, overeating, etc., and is temporary.

In bilious diarrhœa, there is a scalding, greenish evacuation.

Chronic diarrhœa is due to some constant irritation, or from an unrelieved acute attack.

Pain in upper bowel is tormina.

Castor oil has efficient effect on small intestines, salts on the large; the latter runs serum out of blood into lower bowels.

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## RESPIRATORY TRACT AFFECTIONS.—SYMPTOMS, AND TREATMENT.

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BY ARTHUR B. SMITH, M. D., SPRINGFIELD, O.

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The average physician is frequently vexed in finding a condition which resists his best efforts to bring about a cure. This holds good in almost every disease at some time or other, but particularly in affections of the respiratory tract, where there may be a great variety of symptoms in several cases of the same disease.

Almost every physician has some favorite prescription for coughs, bronchitis, laryngitis, etc., which he uses until suddenly it seems to lose its efficacy — why, no one knows. Then another remedy takes its place until it, too, fails to give the desired result. It is rarely that one finds a cough remedy which will be consistently good in the majority of cases. Theoretically there appears to be a well-founded objection to the use of cough syrups in general, but nevertheless there are times when nothing else gives satisfaction; therefore, the physician pins his faith to that remedy from which he and his patients derive the most good. It is not always easy to find such a remedy, but when it is once found, it is equally difficult to dispense with, and often the physician is



almost compelled to resort to a routine treatment. In such cases, of course, he wants the best.

There are constantly being placed on the market new formulas for affections of the air passages. Some of these formulas are of undoubted benefit in some cases, but usually it will be found that the results are far from satisfactory. Many of them cannot be taken when there is any gastric complication, as is sometimes the case, because of consequent nausea and vomiting. Others seem almost invariably to act as cardiac depressants and are highly objectionable for that reason. With the advent of heroin, however, these disagreeable features have, to a great extent, been avoided. Heroin, in the vast majority of cases, can be tolerated by even the most sensitive stomach, and if any disturbance should occur, it can easily be obviated by decreasing the dosage and then gradually resuming the previous amount. Heroin can be prescribed, in cases which are complicated by an enfeebled heart, without danger of depressing effects. As compared with codeine, its sedative action on the respiration is much more powerful. The fatal dose of heroin is said to be one hundred times the efficacious dose, while with codeine the efficacious dose is one tenth of the fatal dose. In other words, heroin is ten times safer than codeine, and can be given in much larger doses, if necessary, without danger. It appears to exert a specific action on the center of respiration without causing disturbances of any other organs or centers, and there is no danger of acquiring any habit by its use.

In phthisical patients the well known lack of appetite and intolerance of various foods renders it imperative to give remedies which will not in any way interfere with the digestive functions, while at the same time controlling or alleviating the cough and other distressing conditions.

Some time ago my attention was called to a preparation composed of a solution of heroin and glycerin, combined with expectorants, called Glyco-Heroin (Smith). Each teaspoonful of this preparation contains one-sixteenth grain of heroin by accurate dosage. It is of agreeable flavor, therefore easy to administer to children, for whom the dose can be easily reduced with any liquid, or by actual measurement. It possesses many



advantages not shown by any other preparation I have used, and has none of their disagreeable features.

In citing some of the cases treated with this remedy I shall not go into a minute description of any case, but briefly state the conditions which existed and the results obtained, which were uniformly good.

CASE 1.—S. B., aged 16. Caught a severe cold while traveling. This developed into an unusually severe attack of bronchitis with mucous rales, pain, cough, and some slight fever. Prescribed Glyco-Heroin (Smith) one teaspoonful every two hours, decreased to every three hours. After a few doses were taken there was a decided improvement, the respirations were slower and deeper, the expectoration freer and the temperature normal. In a few days the patient was practically well and able to return to school. No medicine except Glyco-Heroin (Smith) was given and the results from its use were excellent.

CASE 2.—W. L., aged 31. Acute bronchitis. Painful cough, with difficult expectoration, particularly when in a reclining posture. Glyco-Heroin (Smith) in teaspoonful doses every three hours gave speedy relief and a cure was effected in a few days.

CASE 3.—S. W., aged 60. Chronic bronchitis. Had coughed for years, with expectoration of a thick, yellow purulent and very offensive matter. Had lost flesh gradually until about twenty pounds below usual weight. No appetite, very constipated, pains all over chest, night sweats, and insomnia. Patient on the verge of nervous prostration, and greatly weakened. She was given bromides, a tonic, and Glyco-Heroin (Smith), the latter in the usual dose at intervals of two hours. The first few doses were not well borne, as they seemed to cause some nausea, but by giving a smaller dose and then gradually increasing it, tolerance was soon obtained, and the results were remarkable. The cough and expectoration greatly decreased, the appetite improved, and the patient became much better in every way. The treatment was continued as before, except that the Glyco-Heroin (Smith) was given every three hours. In three weeks the patient was eating almost everything she pleased, and sleeping well. The night sweats had stopped, together with the cough, and, as the patient

expressed it, she "felt like another woman." At present she is in perfect health and needs no medicine except an occasional laxative.

CASE 4.—B. E., aged 26. Severe bronchitis accompanying an attack of influenza. Various remedies were tried in this case, with negative results, until Glyco-Heroin (Smith) was given in teaspoonful doses every three hours. In a short time decided relief was obtained, and the cough stopped permanently.

CASE 5.—R. L., aged 6. Capillary bronchitis with pains over chest, cough, and difficult expectoration. Glyco-Heroin (Smith) administered 15 drops every three hours. After taking a few doses the condition was much improved, and a speedy return to perfect health followed.

CASE 6.—W. H., aged 5. Whooping cough. Spasmodic paroxysms of coughing, sometimes being so severe as to cause vomiting. Tenacious mucus was present, requiring great expulsive effort to loosen it. There was little fever, but the patient was much prostrated and weakened by the cough. Glyco-Heroin (Smith) was given in ten drop doses every two hours with good results. This was combined with hygienic treatment, the patient being given as much fresh air as possible. In a few days the condition was much ameliorated, the cough under fair control, expectoration was freer and easier to raise, and convalescence uneventful. The case was discharged cured and there were no unpleasant sequelæ, the patient at present being in perfect health.

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CAUSE OF CACHEXIA ACCOMPANYING NEOPLASMS.—Quite often a small, non-ulcerating, malignant tumor produces such a marked cachexia that we are at a loss to account for it. It was assumed that the tumor cells secreted a poisonous substance which was absorbed by the system, but no one attempted to isolate this toxin. Early this year, however, Kullmann has found that the cells of cancer contain a substance which rapidly dissolves blood corpuscles. This toxin he isolated and injected into the bodies of animals, producing a prompt and active dissolution of the blood corpuscles. A similar substance has also been isolated from the cells of sarcoma.—*Canadian Practitioner*.

## *Abstracts.*

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### ASPIRATION AND INJECTION OF MORPHIN-EUCAIN IN TETANUS.\*

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BY PROF. JOHN B. MURPHY, CHICAGO.

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A patient treated eight days after infection was given three full doses of antitetanic serum, but without effect; the convulsions increased and were almost continuous. Thereupon a lumbar puncture was made, and 16 cc. of cerebrospinal fluid withdrawn. At the same time 3cc. of the following was injected:—

Beta-Eucain, 1 1-2 gr.; morphin sulphate, 1-3 gr.; sodium chloride, 3 gr.; dist. water, 3 1-2 ozs.

This had been sterilized by boiling. The patient slept four hours immediately and through the night one and one-half hours at a time. There were only eight spasms in the succeeding twenty-four hours. A more severe spasm occurring the next morning, another puncture was made, 15 cc. of fluid withdrawn, and 4 cc. of the above injected. This was repeated on the two following days, and then, with intervals of two days, two more aspirations and injections were made. He was discharged as cured ten days later.

The quantities of morphin and eucain used were exceedingly small, as this was the writer's first case. There was no sweating, headache, or collapse, symptoms frequently noticed after lumbar injections of cocaine. He believes the eucain should be increased to 1-6 to 1-3 grain at each injection, and this treatment might be made more frequent. Eucain is much safer than cocaine, as it admits of boiling, and there is less idiosyncrasy to intoxication. Reduction of the spasms prevents death from exhaustion or interference with respiration. The diminution of pus in the aspired fluid would lead one to believe that lessening of pressure aided the fluid in overcoming infection. There is no reason why the cerebrospinal cavities cannot be washed out by salt or other neutralizing solutions.

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\* Abstracted from *Journal of American Medical Association*, August 13, 1904.

## *Editorial.*

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### ANNUAL COMMENCEMENT AND CLOSING EXERCISES OF THE MEDICAL DEPARTMENT OF THE UNI- VERSITY OF THE SOUTH.

The John S. Cain Medical and Surgical Society held its annual meeting in the auditorium of the medical college on Monday evening, Oct. 24, at 8 p. m., presided over by the President, W. J. Schmidt of Louisiana.

The exercises consisted in talks by the Dean on the value of medical society work and medical organization; by the Rev. Dr. Guerry on the mission and duties of the physician.

Two most excellent papers, one by A. S. Spangler of Tennessee, the other by T. R. Bausch of Pennsylvania were read.

Diplomas were then presented to thirty-two members of the society, attesting honorable membership therein.

The Society then adjourned to the E. Q. B. club rooms, and with the recently organized Alumni Association of the Medical Department, participated in an elegant parting banquet, which was presided over by J. M. Cunningham of Louisiana in his usual felicitous style. Toasts, responses, and speeches by students and members of the other departments of the university were indulged in until a late hour.

The annual commencement exercises of the medical and pharmaceutical departments, and training school for nurses were held in St. Augustine's Chapel at Sewanee on the morning of Tuesday, Oct. 25, a large attendance being present. There were thirty-six graduates in medicine, twenty in pharmacy, and four in the training school.

After a short service, certificates were presented by the Registrar, the Rev. Arthur H. Noll. In the absence of the Vice Chancellor, Dr. J. S. Cain, Dean of the medical school, presided and conferred the various degrees. The valedictory was delivered by Dr. A. S. Spangler of the senior medical class. Diplomas from the Nurses' Training School were presented to Miss Anesta Abernathy, Miss Vera P. Potter, Miss Eloise F. Richmond, and Miss Roberta J. Dunn, after which the degrees of Doctor of Medicine and Graduate in Pharmacy were conferred by Dean Cain. W. B. Hall, M. A., M. D., delivered the faculty charge to the graduating classes. W. J. Schmidt, M. D., Ph. G., of Louisiana, was awarded the medal for the highest honor in the medical class, and James W. Falvey, Ph. G., of Texas, that in the pharmacy class. Honorable mention was made of A. S. Spangler, M. D., of Tennessee, and E. C. Seawright, M. D., of Georgia, in medicine; and of C. R. Reaves, Ph. G., of Tennessee, and W. J. Griffis, Ph. G., of Georgia, in pharmacy.

The degree of Doctor of Medicine was conferred on the following: F. A. Bausch, Pennsylvania; W. D. Bieberbach, Massachusetts; W. N. Breck-

enridge, Virginia; A. M. Buchanan, North Carolina; J. C. Crawford, Pennsylvania; J. W. Crowder, Alabama; J. M. Cunningham, Louisiana; W. T. Dodds, Virginia; R. B. Dunn, Mississippi; R. L. Graham, Texas; J. O. Grove, Pennsylvania; E. C. F. Grumly, New Jersey; L. B. Heimer, Pennsylvania; G. W. Hooker, W. F. Hyde, Virginia; F. V. Jordan, Louisiana; Victor Keidel, Texas; N. W. Lawless, New Jersey; G. W. Lehman, Pennsylvania; J. E. McCreery, West Virginia; H. S. McGowan, Georgia; R. C. Meals, Pennsylvania; E. A. Murray, Massachusetts; Samuel Nicholas, Pennsylvania; D. W. O'Leary, Indiana; D. E. Pierce, Virginia; A. J. Pope, Mississippi; McClure Scott, Virginia; W. J. Schmidt (Faculty Honor), Louisiana; E. C. Seawright, Georgia; W. W. Serrel, Pennsylvania; J. R. Sheldon, Illinois; W. D. Simpson, North Carolina; A. S. Spangler (Valedictorian), Tennessee; Morris Weinberg, Pennsylvania; and S. T. Yoho, West Virginia.

The next session of the Medical Department will begin in April next.

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#### DR. MAYO IN NASHVILLE.

Nashville was honored recently by the visit of Dr. Wililam J. Mayo of Rochester, Minn., and his party.

This great surgeon has come to be more widely and favorably known through his work and writings than almost any other American surgeon, and his visit to this city was the occasion of many courtesies which were extended to him. He was the guest of Dr. W. D. Haggard while in the city, and had been to the Mississippi Valley Medical Association at Cincinnati, O., where he delivered the address on surgery, and also to the Tri-State Meeting at Chattanooga. Accompanying him were his wife and Miss Alice Magaw, his anæsthetist. Dr. and Mrs. A. J. Ochsner of Chicago, and Dr. G. Frank Lydston and Joseph B. De Lee of Chicago. A handsome luncheon was tendered the party by Drs. Fort and Haggard at the Hermitage Club and by Drs. Eve and Witherspoon at the University Club.

Dr. Mayo addressed the students of the University of Tennessee on Saturday morning, Oct. 15. Many physicians from the city and adjoining towns crowded the large amphitheatre to do honor to the distinguished visitor. He lectured upon Surgical Conditions of the Stomach. His large experience and unquestioned authority on this subject added interest to a most practical and instructive discourse, which was illustrated by several very elaborate drawings.

The physiological anatomy of the stomach was described, and attention directed to the many pathological obstacles to its motility and function. Painful digestion was shown to be due to mechanical conditions more often than chemical disorders, and chronic dyspepsia was said to be the name for gastric ulcer sometimes and for the resulting obstruction at the pylorus. The question of drainage of the stomach by gastro-enteros-

tomy was discussed as curative of ulcer and a very certain method of relief in the incurable cases of "dyspepsia" due to pyloric obstruction from chronic ulcer.

A plea was made for early diagnosis of cancer of the stomach by exploratory incision, and the claim advanced that this was the only certain way of diagnosing them sufficiently early for a radical operation on the stomach with hope of permanent cure. Sixteen per cent. of Miculicz's cases remained well and he believed that cancer of the stomach should yield surgically as good results as cancer of the breast.

He said he had seen ten cases of gastric cancer in a medical ward of a large hospital, and that he remonstrated with the internes for treating those cases palliatively, as medicine could not benefit them, but that surgery might and could if diagnosis had been made earlier. Cancer of the breast was not treated in the medical ward, nor cancer of the uterus, or lip, or rectum. The question: Why should cancer of the stomach be so treated? was asked, and the statement made that early diagnosis in suspected cases by exploratory incision was sometimes discouraged by the medical man, but rarely if ever declined by the patient when he was told that if he waited until the diagnosis could be made without incision, surgery would be too late, that incision offered little or no danger; if cancer was found in its incipency, operation could be done, if too far advanced, the closure could be made with strong buried sutures of linen or silk and the man would be up and away from the hospital in a week, and with little risk, expense, loss of time, or absence from home.

Dr. Ochsner, who was expected to lecture upon diseases of the gall-bladder, had been compelled to leave for Chicago the day previous, and in his stead Dr. De Lee spoke briefly but entertainingly upon the vomiting of pregnancy.

Following the addresses at the University of Tennessee, a clinic was held at the city hospital at the invitation of Dr. Duncan Eve. The surgical amphitheater was filled with students of the three colleges. Dr. Mayo lectured upon gall-stones, using a patient of Dr. Haggard's for demonstration and illustration. The etiology was brought out in a most ingenious way, and symptomatology of their various locations was impressed by drawings and charts. The various complications of gall-stone disease were described and the lack of importance of jaundice as a symptom of cholelithiasis was stressed.

The practical and convincing manner in which the facts and truths comprising the natural history of gall-stones was presented was a rare delight. The interesting problems were unraveled as only a man of his vast experience of over 1000 operations could.

Dr. De Lee, through the courtesy of Dr. Altman, described in most pleasing way the methods of external palpation of the gravid uterus, illustrating every detail of the findings.

Dr. Mayo and his immediate party, after spending three days in Nashville left for a short visit to Philadelphia and Boston.

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**SIR WILLIAM ROBERTS ON DIGESTION.**—This great London authority on digestion says: "The digestive change undergone by fatty matter in the small intestines consists mainly in its reduction into a state of emulsion or division into infinitely minute particles. In addition to this purely physical change, a small portion undergoes a chemical change whereby the glycerin and fatty acids are disassociated. The main or principal change is undoubtedly an emulsifying process, and nearly all the fat taken up by the lacteals is simply in a state of emulsion."

This eminent authority is confirmed in the foregoing views by various experiments by which it has been ascertained that fat food passes from the lacteals into the circulation by way of the thoracic duct in the form of an emulsion.

Emulsified cod liver oil as contained in Scott's Emulsion appears in a form so closely resembling the product of natural digestion—as it occurs within the body—that it may well be administered as an artificially digested fat food of the very highest type. In combination with the other ingredients mentioned—glycerine being an emollient of inestimable value—Scott's Emulsion offers to the physician a valuable, exquisite, and rare accession to his prescription list.

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**REAPING PTOMAINES.**—A great many people seem to think that it matters little what kind of material goes into the building of the human structure!

They feed on thorns and expect to pick roses!

Later, they find they have sown indigestion and are reaping ptomaines!

It's a wonderful laboratory, this human body. But it can't prevent the formation of deadly poisons within its very being.

Indeed, the alimentary tract may be regarded as one great laboratory for the manufacture of dangerous substances. "Biliousness" is a forcible illustration of the formation and the absorption of poisons, due largely to an excessive proteid diet. The nervous systems of the dyspeptic are often but the physiological demonstrations of putrefactive alkaloids.

Appreciating the importance of the command, "Keep the Bowels Open," particularly in the colds, so easily taken at this time of the year, coryza, influenza, and allied conditions, Dr. L. P. Hammond of Rome, Ga., recommends "Laxative Antikamnia & Quinine Tablets," the laxative dose of which is two tablets, every two or three hours, as indicated. When a cathartic is desired, administer the tablets as directed and follow with a saline draught the next morning before breakfast. This will hasten peristaltic action and assist in removing, at once, the accumulated fecal matter.

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LISTERINE DERMATIC SOAP is an exceptionally meritorious article which will, we believe, be extensively prescribed by physicians for use in the treatment of diseases of the skin, as the antiseptic and detergent properties of Listerine "Dermatic Soap prove beneficial in the treatment of the various cutaneous inflammations and eruptions, in combating all vegetable and animal parasitic diseases, in diseases of the sudoriparous and sebaceous glands and hair follicles, as well as for the relief of excessive and offensive perspiration. Have your druggist order it from Lambert Pharmacal Co., St. Louis, Mo.

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SOUTHERN MEDICINE, AND GAILLARD'S MEDICAL JOURNAL, beginning with the October issue, are to constitute a consolidated journal. Whatever features in each journal were specially appreciated by its readers will be continued, and no effort will be spared to institute such new ones as experience, coupled with constant observation of the profession's needs, may indicate as being called for.

The consolidated journal will be published at Savannah, Ga., Wm. E. Fitch, M. D., 8 Liberty St., West, of that city being the editor.

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EMPYROFORM.—In an article dealing with some of the newer remedies, Dr. F. Behring, First Assistant in Professor von Dering's Royal University Dermatological Clinic at Keil, says the following concerning it:—

Empyroform, a condensation product of tar and formalin, manufactured by Schering of Berlin, is a remedy calculated to displace all the other tar preparations. It can be employed even in comparatively recent and still oozing eczemas, and we have also used it in the very troublesome and obstinate infantile forms of the disease.

After the most acute stage of eczema has passed under the influence of the usual dessicating remedies, we regularly employ Empyroform salve. We always obtained the very best results and saw no deleterious effects, even in cases where other preparations were entirely useless. Our results were entirely in accord with those obtained in Neisser's Clinic.

The effect of the salve was striking in a number of cases of scrofulous eczema of the face that had withstood every other variety of local treatment. It was an important aid to the healing process, though of course betterment of the general condition had to be striven for. Lichen scrophulosorum and prurigo were also favorably influenced by the drug. In very chronic eczema we found it somewhat too mild and sometimes had to have recourse to pure tar and combinations of this latter with other powerful remedies.

We used Empyroform in the form of five to ten per cent. ointments; and the almost absolute absence of odor deserves especially favorable mention. Intoxication from the drug never occurred.—*Die Therapie der Gengewart*, July, 1904.



GRAY'S GLYCERINE TONIC COMPOUND is invaluable in all chronic and wasting diseases, such as pulmonary tuberculosis, nephritis, gastro-intestinal catarrh, and bowel troubles of children. We have been using it for over twenty-five years, and regard it as one of the best compounds we have ever tried. In the convalescence from any of the infectious diseases, pneumonia, typhoid fever, malaria, etc., its palatability and efficiency have brought it into highest repute.

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CRANIO-MUSCULAR ORIGINS OF BRAIN AND MIND, by Philip H. Erbes, is a book which proceeds from the *unignorable evolution bases*, and yields a new guide for the successful treatment of the multiplying *nervous and mental disturbances*. Illustrated, cloth binding. Price, \$1.20, postage 10 cents. For sale at booksellers, or *The Promethean Publisher*, 622 North Rockwell St., Chicago, Ill.

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A CORRECTOR OF IODISM.—Dr. W. H. Morse reports (*Southern Clinic* for May) success in the use of bromidia, which he says has proved corrigental of iodia. Discussing his results he says: "Vomiting is so frequent and troublesome a symptom in many diseases besides irritation and inflammation of the stomach, as to demand much practical attention from the physician. So, although the causes are so various, and although we are actually treating a symptom, for this symptom bromida is remarkably effectual. We have all employed the remedy for colic and hysteria, two disorders where nausea and vomiting are as pronounced as they are persistent, and almost the first evidence of relief is shown by the disappearance of these disagreeable symptoms. It is quite as efficacious for the nausea and vomiting from ulcer or cancer of the stomach. There is nothing that will more quickly check the vomiting, and the hypnotic effect is quite in order.

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MISSISSIPPI VALLEY MEDICAL ASSOCIATION.—The officers elected at the 30th annual meeting of this Association, held at Cincinnati, O., Oct. 11-13, are as follows: President, Bransford Lewis, M. D., St. Louis; First Vice-President, Frank Parsons Norbury, M. D., Jacksonville, Ill.; Second Vice-President, J. H. Carstens, M. D., Detroit, Mich.; Secretary, Henry Enos Tuley, M. D., Louisville, Ky.; Assistant Secretary, John F. Barnhill, M. D., Indianapolis, Ind.; Treasurer, S. C. Stanton, M. D., Chicago, Ill.

Next place of meeting, Indianapolis, Ind., October, 1905.

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KENNEDY'S EXTRACT OF PINUS CANADENSIS is a valuable agent in chronic diseases of the mucous membranes, and admirable for the removal of morbid discharges of every kind.

**A NEW DEPARTURE.**—In these days when a glib public prescribes for itself from the patent medicines on the frieze of the trolley-cars, or takes the profitable substitution that the druggist passes over the counter, it is no wonder that physicians feel a bit out of sympathy with the venders of drugs, and make unfavorable comparisons between the commercialism of the men who supply medicines and the science of the medical profession that prescribes them.

But we should never forget that were it not for the great manufacturers and importers of drugs, we might still cut our own herbs and use our own mortars and pestles. As an indication of the aid that such houses may be to physicians, we call attention to the colored plates of pathogenic organisms that have been prepared for the profession by the house of M. J. Breitenbach Co., the importers of Gude's Pepto-Mangan.

No text-book, and no work on pathogenic bacteria contains such a number of excellent diagnostic illustrations, nor such beautiful examples of lithographic art, as these.

Many physicians are too far from libraries and laboratories to be able to put into practice the training of their college days. They need just such a set of reference plates to be able to make microscopical examinations. The recognition of this need and the care that has been taken to fill it shows a spirit of enterprise in this firm that we wish might serve as an example to others. For, if, instead of advertising to the public, the manufacturers of drugs would make such valuable contributions to science as lies in their power, there might be more sympathy between them and physicians.

The full set of sixty cuts has been prepared to send to any physician who writes for them, from the firm of M. J. Breitenbach Co., New York.  
—*Medical News.*

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THE GOVERNORS OF THE NEW YORK SKIN AND CANCER HOSPITAL announce that Dr. L. Duncan Bulkley will give a sixth series of clinical lectures on diseases of the skin in the out-patient hall of the hospital on Wednesday afternoons, commencing November 2, 1904 at 4:15 o'clock. The course will be free to the medical profession.

WILLIAM C. WITTER,

*Chairman of Executive Committee.*

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**TYREE'S ANTISEPTIC POWDER** contains sod. bor., alumen, ac. carbol., glycerin, the cryst. principles of thyme, eucalyptus, gaultheria, and mentha.

For leucorrhoea, gonorrhoea, vaginitis, pruritis, and ulcerated conditions of the mucous membranes, one to two teaspoonfuls to a pint of water three or four times a day. For scrofulous, syphilitic, and varicose ulcers, apply the powder full strength or dilute with boracic acid. As an ointment, use from one to three drachms to one ounce of petroleum. For spraying the nose and throat, from twenty-five to one hundred grains to one pint

of water (dissolves immediately). For *immediate* deodorizing and disinfecting, sprinkle the powder direct upon the object affected; the results will be instantaneous. For prickly heat, poison oak, squamous eczema, and other conditions of a similar nature, use from one to eight teaspoonfuls to a pint of water (has proven very servicable for these conditions). As a deodorant and prophylactic in dental work, use one to two teaspoonfuls to a pint of water. For disinfecting offensive cavities, fill them with the powder. For profuse and offensive perspiration, swelling, soreness, and burning of the body and feet, use full strength or diluted with water. As a delightful toilet preparation after the bath and shaving, from one to two teaspoonfuls to a pint of water. The price is practically nothing. Ten cents worth will make one gallon of standard solution.

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NEW ORLEANS POLYCLINIC:—*Eighteenth Annual Session opens November 7, 1904, and closes May 20, 1905.* Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory and cadaveric work.

For further information address, New Orleans Polyclinic, Post-office box 797, New Orleans, La.

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## *Reviews and Book Notices.*

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A TEXT-BOOK OF PHYSIOLOGY. By Isaac Ott, A. M., M. D., Professor of Physiology in the Medico-Chirurgical College of Philadelphia. With 137 illustrations. Royal Octavo, 563 pages. Bound in extra cloth. Price, \$3.00 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This is a "new one on us," but from what we have been able to see from a careful examination, it is a good one. However, we will let the author speak for himself and give his modest preface in full. He says: "This book was written at the solicitation of students who have attended my lectures for the past eight years. The aim has not been to write a treatise on the subject, but rather an elementary work containing the chief facts of physiology which are necessary to the student who wishes to apply them in the practice of his profession. Physiology is the basis of medicine, and its understanding is requisite to the study of pathology. With this idea in mind, small space has been given to the subject of electro-physiology. The technique

of the laboratory has been omitted for similar reasons. In the preparation of this book it was found impossible to give due credit to all sources from which information has been derived.

"The illustrations have been selected from various authorities, to whom credit has been given."

**KIRKE'S HANDBOOK OF PHYSIOLOGY**, revised by Frederick C. Busch, B. S., M. D.; Professor of Physiology, Medical Department University of Buffalo. Fifth American Edition. 8vo cloth, pp. 862, with 535 illustrations, many of them in colors. Wm. Wood & Co., New York, 1904.

Kirke's has for many years been a standard and almost universally read text-book in the leading medical schools of this country; and with increasing age the successive editions are very markedly improved.

In the present edition many changes have been made in order to conform to well-established advances in the various fields of the science. The text has been condensed in places, and elaborated in others when it was deemed advisable for the better elucidation of the subject matter.

The most marked changes are to be noticed in the chapters on the blood, circulation, respiration, food and digestion, and muscle and nerve physiology.

A number of illustrations have been replaced by others more fully and clearly elucidating the text, and a number of new ones have been added.

**A TEXT-BOOK OF DISEASES OF WOMEN**, by Charles B. Penrose, M. D.; formerly Professor of Gynecology in the University of Pennsylvania, Surgeon at the Gyncecan Hospital, Philadelphia, 8vo, cloth, pp. 550, with 225 illustrations. Fifth edition, revised. Price, \$3.75. W. B. Saunders & Co., Publishers, Philadelphia, New York, and London, 1904.

This book was written for the medical student, but practitioners will find it of very material value. It gives the best views of modern gynecology, untrammelled by antiquated theories or methods of treatment. The very able author in many instances advises but one method of treatment for each disease, hoping in this way to avoid confusing the student or those consulting its pages for practical guidance. Facts pertaining to anatomy,

physiology, and pathology found in the general text-books on these subjects have been omitted; yet such facts are mentioned in detail when necessary for thorough elucidation of the subject, or when there are certain facts, especially of pathology, peculiar to the disease under consideration.

This edition has been carefully and thoroughly revised, and numerous additions will be found, rendered necessary by the progress and increase of knowledge of female diseases.

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## *Selections.*

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**HYDRAGOGIN: A VALUABLE HEART REMEDY.**—It was my fortune about six months ago to learn of hydragogin as a heart remedy. A circular by Dr. Watson of this city, in which he related several interesting cases in his clinical experience with the remedy, happened to fall into my hands. I was so impressed by his clinical deductions that I resolved to make use of this remedy at my earliest opportunity. Unfortunately I was unable to obtain any other literature upon this subject. From this circular, however, I quote the following which explains its pharmaceutical principles and its physiological action in disease:—

“Fifteen parts of hydragogin represent 1.5 parts tincture of digitalis, 2.5 parts tincture of strophanthus, scillipicrin, and scillitoxin, which are the active principles of scilla maritima, and 0.5 parts oxysaponin, which is obtained from herniaria glabra. Probably this last ingredient is the most important; at least this is the consensus of opinion on the subject, and the action of this substance on the system certainly deserves to be further investigated. Oxysaponin is a gray amorphous powder and has a pungent, irritating odor and rather a flat taste; it is sternutatory and foams readily on being shaken.

“Hydragogin acts directly on the cardio-vascular system, kidneys, and bowels. The action of the tincture of digitalis and strophanthus on the cardio-vascular system is well known; the arterial tension being increased throughout the body, it necessarily follows that the blood pressure is increased in the kidneys. Scillitoxin, which are the active principles of scilla maritima, and

the epithelial lining cells of the uriniferous tubules of the kidneys, producing diuresis. Oxysaponin, when administered alone, excites diuresis and causes watery stools; hence we see that the action of hydragogin is freely diuretic and cathartic."

We learn by this that the object desired in using this remedy is not alone to obtain diuresis, but its action upon the hepatic function also gives relief to the bowels and thus acts directly for the relief of extreme edema and dropsy. We know full well that this is our greatest aim in the treatment of severe cardiac cases, particularly where the right heart needs relief. Hydragogin in its direct action upon the cardio-vascular system comes to our aid decidedly in this respect. Nephritis, which is such a common complication in heart troubles, is thus greatly relieved by its action. Uremia, hepatic cirrhosis, and the inflammations arising from uric acid irritations also respond readily to its administration.

In my previous treatment of heart diseases it has always been a difficult matter to find a remedy which would promptly and surely relieve these extreme signs of edema and dropsy. Many remedies will act temporarily in this respect, but none in my experience heretofore, have given any lasting help. It has thus been necessary to seek the surgeon's aid by the multiple incisions in the ankles or the trochar in the abdomen. I have always found, whenever these methods were resorted to, that the dropsy increased later until repeated surgical interference in this respect was called for. We all know that as soon as we begin to relieve abdominal ascites in this respect the condition gradually becomes aggravated until no help is possible.

My first case in which I attempted the use of this remedy was the worst I have seen for some time. A lady, forty-five years of age, had been suffering for a long time with a pronounced aortic regurgitation and a relative mitral insufficiency. She had been under the care of another physician who had abandoned hope. When I was called it was only as a last resort. I found her sitting in a chair and the abdomen was terribly distended with ascitic accumulation. The limbs were so edematous that she was obliged to support them constantly in another chair. The respiration was labored and cyanosis was pronounced; the

heart was struggling under a marked weakness and arythmia; the pulse was rapid and intermittent and the lung edema was excessive. The amount of urine did not average more than four hundred cubic centimeters in twenty-four hours. Urinary examination revealed an abundance of albumin and many granular casts.

The patient had not been able to sleep much and was obliged to rest at night in the upright position in a chair. The outlook was apparently unfavorable, and we did not expect to do more than give temporary relief at best. Normal salt enemata were used regularly and the patient was compelled to drink copious draughts of distilled water. Hydragogin, in fifteen drop doses, was given every three hours. In a few days the amount of urine increased somewhat and the patient began to breathe more freely. In two weeks' time the diuresis was so complete that she passed daily nearly two quarts of urine. The dropsy began to disappear and the heart's action improved considerably. By the aid of intercurrent indicated remedies we were able to correct many of the other disturbing symptoms, and the patient was able to sleep quite comfortably in the recumbent position.

At the end of the month we were astonished at our patient's improvement. Nourishment was tolerated and the strength gradually improved. The heart steadied down decidedly and the cyanosis disappeared with the improved dropsical conditions. At the end of the second month, another examination of the urine was made, and to our greater astonishment the albumin had entirely disappeared and the granular casts were few in number. This was the most encouraging surprise of all, and it taught me that we had evidently found a very valuable remedy in these serious cases. It is now the fifth month since I undertook the treatment of this case. The patient is apparently enjoying fairly good health, and I only make an occasional visit. She goes out every day and walks for blocks without any apparent discomfort. She is daily gaining flesh and strength and says she feels perfectly well. While the cardiac lesions are still in evidence, the compensation is sufficient to give fairly good heart action. I really believe that we shall prolong her life decidedly and give her a fair degree of comfort. This is more than I have



ever done in a similar case before. It makes me feel that we have found in hydragogin a remedy which will be worth much to us in the treatment of these cases.

About the time I took this case I was called to two similar ones in consultation in the country. The same remedy was employed, and my correspondence with the physicians in charge has revealed similar reports of good results. It is my hope that other physicians may find equal comfort in the use of this remedy.—*H. V. Halbert, M. D., of Chicago, in The Clinique, Nov. 15, 1903.*

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SCIENTIFIC WORK ON COCA.—It may be of interest to note that the Mariani products have not been merely pushed upon the market commercially, without any regard to scientific details. In the laboratories at Neuilly, France, the coca plant is studied botanically and chemically to determine how best to develop its properties. From there thousands of plants have been sent to the principal botanical gardens throughout the world, and every effort is constantly made to study this substance, and to afford others an opportunity for its scientific investigation. This is related not as a matter for mere praise, but to impress the fact that here is the largest manufactory of exclusive coca preparations in the world. This could not have been so extensive, nor so successfully maintained through all these years, if it was not founded upon merit and conducted upon those liberal principles which unite all that is possible scientifically with mere commercial interest. Thus it will be seen, that whatever has been done toward advancing the popular use of this restorative substance, has been the outgrowth from the original conception of preserving the true qualities of recent coca in a nutritive wine.

These are but some reasons why it would seem that whatever this firm has to present to its friends, the practitioners, should command consideration. Vin Mariani was nearly fifty years ago introduced to the medical profession. It has been endorsed by physicians everywhere, and whatever success has been achieved through it is due to those physicians who, having recognized its worth, have since continued to employ it.—*The Coca Leaf, November, 1902.*



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## ENURESIS.

R. Strychinæ sulph..... gr. j  
Pulv. cantharides..... gr. ij  
Morphiæ sulph..... gr. iss  
Ferri redacti..... gr. xx  
Ms. ft. pil. No. 40. Sig.: One pill three times a day for a child of ten years of age.—*Gross.*

## ACUTE CYSTRITIS.

R. Atropinæ sulph..... gr. j  
Acidi acetici..... gr. xx  
Alcoholis .....  
Aquæ..... aa ʒ ss  
Ms. Sig.: Four drops in a wineglass of water before each meal.

## CONSTIPATION.

R. Hydrarg. chlor. miti..... gr. iv  
P. aloes.....  
Ext. nucis vom..... aa gr. xvj  
Ext. Belladonna..... gr. iij  
Ol. piper niger..... gt. vj  
Ext. hyoscyam..... ʒ ss  
Pulv. rhei (Turkish)..... ʒ ij  
Ms. ft. pil. No. 64. Sig.: One pill once, twice, or three times a day.

R. Podophylli resinæ..... gr. ij  
Quininæ sulph.....  
Ext. aloes..... aa gr. viij  
Fellis bovinæ..... gr. xvj  
Ms. ft. pil. No. 16. Sig.: One or two at bed-time.—

*Modell.*

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WHOOPIING COUGH,  
ASTHMA, Etc.**

Impose a tax upon the resources of every physician renders it opportune to re-invite attention to the fact that the remedy which invariably effects the immediate relief of these disturbances, the remedy which unbiased observers assert affords the most rational means of treatment, the remedy which bears with distinction the most exacting comparisons, the remedy which occupies the most exalted position in the esteem of discriminating therapeutists is

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## HICCUGH.

R Amyli nitris.....fl. 3 j

Sig.: Three to five drops on handkerchief by inhalation.

Indication.—Used in obstinate hiccough.—*Exchange*.

## ANÆMIA.

R Ext. glandulæ suprarenalis.....3 ij

Pone in capsulas No. xxiv.

Sig.: One capsule after meals.

Indication.—In pernicious anæmia.—*Exchange*.

## EPSOM SALTS MADE PALATABLE.

R Magnes. sulp.....℥ ss

Acid sulph. dil.....m ij

Syr. limonis.....℥ iss

Aq., q. s.....ad ℥ ij

M. Sig.: One dose.—*Exchange*.

## PHOSPHATURIA.

R Saloli.....3 iij

Ft. chartulæ No. xxiv.

Sig.: One powder before meals.

Indications.—In phosphaturia with ammoniacal decomposition of urine.—*Exchange*.

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tificate), cut out this advertisement, attach the certificate and mail both to us and we will send you free of charge, one of these elegant Hypodermic Syringes which sell everywhere for \$2.50 each; this offer for one time only to each physician, afterward the certificate will be redeemed according to our regular plan. Write for our premium catalogue and see how we are able to make such elegant presents to our customers. If you can not get Bronchiline of your jobber, send us \$2.50 and this advertisement and we will ship you the Bronchiline and Hypodermic Syringe, you paying the Expressage.

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### CYSTITIS.

The following combinations are recommended in the *Medical Record* in the treatment of cystitis:

R. Liq. potassae.

Olei santali..... aa ℥ii

Aq. cinnamoni q. s. ad..... ℥vii

M. Sig.: Two tablespoonfuls three times a day; or

R. Potass. bromidi.

Sodii bicarb..... aa ℥iss

Ext. belladonnae..... gr. iv

Ext. buchu..... ℥i

Syr. sarsap, comp. q. s. ad..... ℥iv

M. Sig.: One tablespoonful three times a day, in water.

And for chronic pyelitis, accompanied by pain, the following combination is recommended:

R. Terebenthinae Venice).

Pulv. camphorae..... aa ℥iss

Ext. opii..... gr. v

Ext. aconiti rad..... gr. iii

M. Ft. pil. No. xx. Sig.: One pill every eight hours, with a small glass of the infusion of uva ursi, sweetened.—*Medical Chicago Journal*.

### DYSPEPSIA.

R. Saloli ..... ℥ j

Ft. chart. No. xxx. Sig.: One powder before meals.

Indications.—Used in intestinal indigestion with fermentation.—*Exchange*.

### DIABETES MELLITUS.

R. Pulv. opii..... gr. xxiv

Acidi gallici..... ℥ ij

M. et pone in cachetas No. xxiv.

Sig.: One cachet two hours after food.—*Exchange*.



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### A SUBSTITUTE FOR MILK IN INTESTINAL DISEASES OF CHILDREN.

Helprin, in the *Medical Record*, recommends the following, which may be used in place of barley water when that mixture becomes monotonous or distasteful:—

“Two tablespoonfuls of ordinary flour in an agate dish retained in an oven till the flour is well browned, then blend or dissolve in a little cold water; this is now gradually added to, and stirred into, two pints of water while boiling. This may be given in three-ounce apportions, and ten feedings. One half dram, gradually increased to a dram and a half, of condensed milk can, in the course of a day or two, be judiciously added to each feeding.”

Other preparations of the same class include cornstarch and granum. He also recommends the following prescriptions to be used to hold a diarrhoea in check:—

R. Bismuthi subnitratis..... ʒ v  
Bismuthi salicylatis..... gr. xii  
Syrupi rhei aromatici..... ʒ iii  
Aquæ dest. q. s. ad..... ʒ iv

M. Sig.: Teaspoonful every two to four hours.

For the same condition Kerley recommends the following:—

R. Bismuthi subnitratis..... ʒ v  
Sulphuris sublimatis..... gr. xxx

M. Ft. chart. No. xxx. Sig.: One powder in a tablespoonful of water every two hours. The effect is soon evidenced, but it is best continued for some time.

---

### CHLOROSIS.

R. Ferri arsenitis..... gr. ij  
Ext. cinchonæ..... gr. xij  
Ft. pil. No. 12. Sig.: One pill after each meal.

OR

R. Pepto-Mangan (Gude)..... Oj  
Sig.: Tablespoonful in two tablespoonfuls of sherry wine just before each meal.

---

### COLLAPSE IN PNEUMONIA.

Inject into each arm hypodermatically, ʒ i of a ten per cent. solution of camphor in oil.



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EDITOR AND PROPRIETOR

Vol. XXVI.

NASHVILLE, DECEMBER, 1904.

No. 12

*Original Communications.*

HYSTERIA\*

BY J. R. BUIST, M. D., OF NASHVILLE, TENN.

As all of you know, the term hysteria is of very ancient origin; but has long since ceased to have any etymologic significance. The suggestion to employ some other name to designate this strange disorder has been repeatedly made, and as often abandoned. In late years many have tried to make "Functional" a preferable synonym, but the word is open to many objections. It is probable that the old name will remain in general use until we have a better knowledge of the inner nature of the disease.

Instead of attempting a formal definition of the disorder, we prefer to give some of its peculiar characteristic features as we

\* Read at Meeting of Nashville Academy of Medicine, Tuesday, Nov. 1, 1904.

find them drawn by the highest standard authorities, in order that we may have a common reciprocal plane of thought to rest on:—

First, let us bear in mind that we have to deal with a real, definite entity, a derangement distinct from all other morbid states, with no causal relation to uterine pathology, and not at all synonymous with shamming and malingering.

It is essentially a psycho-neurosis, combining abnormal mental and moral phenomena with disorders of the cerebro-spinal functions. The symptom-complex is the most remarkable and bewildering in the whole range of clinical medicine, giving rise to the saying that hysteria masquerades many other diseases. Yet in all these varied phases it has an unmistakable physiognomy, that may be recognized as soon as the mask is removed.

It is believed by all modern writers that the symptoms rest upon a basis of an inherited peculiar temperament or diathesis. There must always exist an underlying inherent instability of the nerve centers, and of the emotional nature. That it is in one sense a chronic malady, but in most instances presents remissions—periods of quiescence, interrupted at indefinite intervals by paroxysmal outbreaks—that different persons are affected in a greatly different degree and intensity, are well recognized. In some the disturbances are mild, so light as hardly to constitute disease; in others, violent, alarming, and distressing. Another well-known feature is that the symptoms may come suddenly, last an uncertain time, then disappear and leave no injurious sequel.

*Etiology.*—The more this disease has been studied the more the investigators believe it to be purely functional in its character; that is, that it is not directly dependent upon any gross change in the nerve centers; no anatomical base can be assigned; a conclusion not merely drawn from lack of post-mortem changes, but also made positive from the character of the phenomena and manner in which they supervene, and their sudden disappearance. The apparent unconsciousness more nearly approaches sleep than coma; the hysteric palsies last for months without organic change in the muscles, and recovery ensues. The ophthalmoscope shows no changes in the fundus of the amblyopic eye, and restoration

to sight is complete. Such perversions of functions are incompatible with organic lesions. Of course it is probable that some alteration takes place in the cellular structure of the cerebral cortex and elsewhere. Of the nature of this we are still ignorant.

In its causation, as in that of other diseased conditions, there is never a single factor responsible for the phenomena. Many preceding and accompanying conditions must act together in securing the result. But, perhaps more than in other diseases, individual predisposition or temperament alone has the larger share in giving us this group of morbid phenomena. In fact, modern medicine teaches us that the substratum of hysterical symptoms, the essential antecedent condition, is an inherited idiosyncrasy, an unstable constitution of the nervous system. This congenital defect may be very slight, but it is easily exaggerated in early life by many circumstances, as it is then that the nervous system is weakest and the emotional nature uppermost.

Reliable statistics show that 70% of hysterics are the offspring of neuropathic parents, while exact knowledge regarding the other 30% is wanting. Among the proximate causes sex is to be given the first place — at least 80% of cases occur in females. This does not mean that the sexual organs of the female are the direct controlling factors, whether they be normal or diseased. It only means that the nervous constitution and emotional nature of women is constructed on a different type from the male. Females are more susceptible to the exciting causes of hysteria; they possess a more unstable state of the neuro-psychic part of our nature, just as in early life of both sexes this faculty is more impressionable.

It is well known that race and nationality exercise a decided influence upon the frequency of occurrence, as well as upon the intensity of symptoms. Thus the Latin races are specially susceptible, the French people in particular. Next, it is said, the Jewish, and then the negro race. The severe types of hysteria, called by the French *hystero-epilepsy*, seem to be rare among English-speaking people.

A proximal cause, dwelt on by many writers as one responsible for untold bad effects, is the influence of improperly rearing of children. A defective home training and careless indulgence

of whims and inclinations of the young. Under such influences the child grows up to adult life without healthy self-control, without sensible and purposeful objects in life, and carries along a weak, puerile, and impressionable emotional nature, all of which too often results in making a poor, hysterical invalid, one who is the source of sorrow and affliction to the home.

Age exerts great influence upon the number of cases in both sexes. Before puberty we find the largest number developing their first attack; then, next, is the first decade of adult life. After forty, hysteria is found only in those who have light natural susceptibility, but who have been exposed to severe and powerful exciting causes.

It is very evident that all the factors that excite the hysterical states act through the mind, or, more strictly speaking, through the emotional faculties. This is one evidence of the distinctive individuality of the disorder.

Sudden fright, great grief, disappointments in love, the loss of fortune, family infelicities, are some of the circumstances that often initiate the crisis in the predisposed. So, also, accidents in vehicles, railroad wrecks, a house on fire, are common causes, although the personal traumatism may be slight or absent.

*Symptomatology.*—Clinically the patients are divided into three classes, those with simply a hysterical temperament; those subject to light and short attacks, known in text-books as hysteria-minor; and those with fully developed symptoms in the paroxysms, and permanent marks or stigmata during the interparoxysmal period, known as hysteria-major.

It is hardly proper to consider the first class of cases as patients; they possess nervous, impressionable natures, but may live a life-time without any outbreak of hysteria proper. They are on the border land.

The second class cannot be separated by any well-defined limit from the third, one passing into the other by insensible gradations.

In the milder cases the hysterical status exists, and is characterized by emotional instability. The person is prone to weep or laugh, without sufficient or obvious cause, and evidently beyond her power to control the manifestation of these opposite

conditions. There comes over such persons a moodiness of disposition, and often a morbid sensitiveness, which the friends and relatives cannot understand, or a fit of anger may appear under trivial causes, ending in bitter sobbing and weeping. Under these excitements the lump in the throat, the familiar "globus hystericus," occurs. They are liable to have the localized sharp pains at the top of the head, sometimes near the temples and along the left side of the chest. These cases sometimes have slight convulsive attacks, or rather they are given to yawning, stretching the limbs, rolling over in bed and striking out with their arms, then going off into a trance. After such states there will be a profuse flow of clear urine of a very low specific gravity.

A close familiarity with these patients will impress upon the medical attendant some very curious mental states. There is an absence of any serious apprehension of danger, a pleased vanity in telling of their ailments. They are readily acted on by auto-suggestion, and become hypnotized easily. Any serious disturbance in the family, sudden illness, accident, or death, when it is better for every one to keep cool and have their wits about them, causes these persons to go off unexpectedly into immoderate crying, violent excitement, or a half unconscious trance, adding greatly to the already existing distress.

Persons who have been subject only to the milder forms may eventuate with the symptoms of hysteria-major. More frequently the severe types occur *de novo*. The features here presented are much more pronounced and serious, and in their full development highly dramatic. These extreme conditions are not often seen among the English-speaking people, but were very common in the Middle Ages, and still frequent in France, and among the negroes of the South, chiefly under religious emotion.

In the violent seizures or paroxysms, when the stages come in regular succession, the scene is very striking and remarkable. There is first a prodromal stage, in which the disposition and behavior of the person is changed. The friends observe something wrong in this member of the family, she being either mentally depressed or very irritable. This continues to last

several hours, or a day or two, when a paroxysm takes place. She may fall to the floor with a cry, twitch and jerk, eyes roll and lids quiver. Tonic spasms, alternating with clonic, supervene, with seemingly unconsciousness, presenting much the appearance of epilepsy; this is known as the epileptoid stage. There is never injury to the person, or any biting of the tongue; no relaxing of bladder or anal sphincters. This convulsive state lasts four or five minutes and passes into a quiet coma. Then the second stage succeeds, in which the limbs and body are rigid and stiff for a few minutes; extensive movements, twistings, and contortions of the limbs. The attitudes are remarkable, sometimes assuming the most complete opisthotonus seen in tetanus. This has been designated by the Charcot school as the stage of "grand movements," and continues for about five minutes.

The scene now changes, and the patient passes into a state of the most lively emotions, expressed in fits of laughter or anger, and then weeping or sobbing. To this often succeeds wild delirium, which may last several days. These paroxysms constitute what Charcot has so accurately and beautifully described under the term hystero-epilepsy, a term not accepted by the writers of the present day. There is no epilepsy combined in the case, and only one of the stages in which the term epileptoid is approximate. Ordinarily, the regular succession of phenomena above described is wanting; in fact, outside of France such complete paroxysms are hardly known. It is, however, by the study of these fully developed cases that Charcot and his school were enabled to clear away the confusion that had so long existed on the nature of functional disease, and to advance our knowledge to its present satisfactory stage.

When we turn to that group of symptoms which succeed to these crises, we see symptoms equally remarkable and as unique as those we have just described. These special symptoms, however, are not necessarily interparoxysmal, but are found in the hysteric independent of any preceding fully developed attack. They consist of either motor, or sensory, or special sense derangements, or a combination of all. There are marks or stigmata of great importance in the differentiation of hysteria, because

they are objective evidences, and subjectively unknown to the patient.

In certain cases the integument of the entire half of one side of the body is found to be insensible to pain — hemi-anæsthesia — in other cases the anæsthesia is local, embracing the segment of an arm or a leg, and then again it may be in patches, but never following the distribution of a nerve or system of nerves. Hyperesthesias are also, though not so commonly, among the marks of chronic cases. More frequently it occurs in spots, and is localized; for instance, in the female over the ovaries, and in males in the same region and the scrotum, over the epigastrium and under the mammæ, and on the back near the spine; these sensitive spots, when pressed upon, may develop a crisis, and are known under the term "hysterogenic zones." Not an unfrequent affection is the impairment of sight in one eye, varying from a limited concentric contraction in the visual field to complete amblyopia. This eye trouble may last a long time, and exist often without the knowledge of the patient, so that the suspicion of shamming is not tenable. The ophthalmoscope fails to show any abnormal change in the fundus, so it is clearly functional.

Along with these sensory disturbances are apt to exist motor symptoms. We should here state that all the interparoxysmal marks have a decided preference for the left side of the body. You may find hemiplegia, paraplegia, or monoplegia in these cases. Paralysis of the left arm is most common, and next, of the leg, the face never being implicated. The palsy is a flaccid one, and the loss of power never as pronounced as in organic lesion of the nerve centers. In the hemiplegia of hysteria the patient in walking drags his legs after him; in that from brain lesion, throws the foot around in a half circle. This sort of paralysis is never attended with the usual atrophy consequent upon other forms; nor are the electrical changes present. The deep reflexes are either not altered, or at least not exaggerated. In some cases external strabismus exists, due to palsy of the internal recti muscle. Along with or following these palsies may supervene contractions in the muscles of the extremities, either in flexion or extension, which perfectly counter-

feit such as occur in joint affections and in cerebral lesions. These contracted muscles will resist very powerful efforts at reduction, but as soon as ether-narcosis is reached thorough relaxation occurs. A slight blow or pressure on a muscle will in some instances produce a temporary contraction or rigidity. Another form of irregular muscular action sometimes occurring is tremors that simulate those seen in paralysis-agitans, neurasthenia, intentional tremors, etc. In all of the above described hysterical manifestations, whether in the activity of the crisis or in the milder chronic conditions, it is easy to recognize that no impairment of the higher intellectual faculties results. The vicious circle which takes in large egotism, a love of sympathy from attendants and friends, a loss of will-power, a satisfied complacency with their suffering lot, and the appearance of a morbid desire to be regarded as martyrs, is constant and conspicuous.

Although the world has long since set aside the belief entertained in the Middle Ages of the criminal depravity of the victims of hysteria, and abolished the cruel punishments to which they were then subjected, yet the cunning and deceit that is sometimes observable, even in refined and well-educated persons, is enough to try the patience of both the family and physician. Indeed it is hard sometimes to control our disgust and anger. The fact is, a certain amount of discipline and stern command is usually needed in the successful management of hysteria.

We give here clinical histories of some cases we have had, personal observation of which will further illustrate the above brief sketch of symptomatology.

I once had under my care a lady whose history is as follows: She was a person of good physical constitution, handsome, and without apparently any inherited predispositions. She was intelligent, well educated, and belonged to one of the first families of the South. Some six months after marriage her husband was killed in one of the battles of the Confederate war. The shock entirely prostrated her, and she was ever after an invalid, with only remissions in the early part of her illness of from two to twelve months duration.

When I first saw her she had been affected seven or eight years. She was even then stout and plump, and of healthy



appearance. She had been in the hands of many physicians. A few years after the war she fell into the hands of the gynecologists, who at that time were just starting on their special line of work. As the accepted theory at that time was that nervous affections in the female always originated in the womb and ovaries, the gynecologists soon went to work on these organs. She received local treatment *ad nauseam*, a great variety of pessaries were tried, she remained months at a time in sanatoria, had the best skill in this line in the metropolis, kept employed always at home trained nurses, traveled much, and spent money freely, but notwithstanding she had grown steadily worse.

I was informed that she had "falling of the womb," and had to wear a supporter, and that she had neuralgia of the ovaries. She was taking hypodermics of morphine quite often, spent much of her time in bed, and her physician had to see her several times both night and day. I recollect my being called up after midnight the following night, and when I entered the room the scene was on. She was on her back, her thighs flexed over the abdomen, and her hands clasping her knees. She was straining with all her might, as if in the last stage of labor. The nurse was at her head stroking her face, the sister was in tears, and the brother-in-law in great distress. All begged me to give her some morphine, for she had to have it. I injected the morphine, and then examined the vagina, and found the womb half outside the body. After struggling and bearing down for ten or more minutes, she dropped back on her pillow, began to sob, and soon went off into a trance which the nurse said would last five or six hours. The pessary was expelled during this tenesmus. She was then expected to vomit for a day, which she did the next day. She was excessively tender over the ovaries, the hystero-genic zones. Being then a young man, ignorant of nervous affections, I accepted the diagnosis and treatment of more distinguished men. I treated her faithfully five or six years with tampons and pessaries and frequent doses of morphine. The uterine attacks would come on once or twice a month for a while, and then rest maybe for several months. The scene was varied by the occurrence of swooning fits and long half-unconscious states, with attacks of depression and weeping,

although generally she was in good spirits, and liked her room full of company. She would eat scarcely anything for weeks, and often would have attacks of uncontrollable vomiting, but maintained her weight all the time. She finally left me and went to New York to try a new gynecologist, where she remained several years. I learned she became a physical wreck, used morphine in large quantities, and died about twenty years after her terrible shock.

Of course at that time I never thought of hysteria, nor any one else, for neurology was then in its infancy. I look back now and recognize it was a typical case, and she would have been better, certainly no worse, if she had never seen a gynecologist.

Years ago I was the family physician of a man who possessed a fine natural constitution, powerful physique, and apparently inherited no taint or proclivity to disease. When his health failed he was about middle age; he had never drank spirituous liquors, but used tobacco to the greatest excess. He had been brought up without parental control, and was accustomed to have his own way in everything. The first evidence that he was out of his usual health was at the end of a very trying and exciting campaign, in which he was deeply concerned. During these few months he led a very irregular life, and was at times exposed to a very hot sun. He complained of headaches and insomnia, and once or twice fell over on the floor, apparently from exhaustion. In addition to the over-excitement he had passed through, he discovered his finances to be in bad shape, and that he had likely lost his fortune. He had at the beginning a painless diarrhoea, which steadily increased and became a mucous diarrhoea. He lost flesh rapidly. His disease was pronounced by one of the best New York physicians to be amoebic dysentery, and likely to end him in a few months. Some six or eight months after his illness commenced, he began having fits, simulating epilepsy. They recurred once every few weeks at first, then three times a week, and finally every day, and for two or three years they recurred at the same hour of the day. These attacks were never tonic convulsive seizures; they consisted of a rigid state of the arms and chest, some little jerkings, would tear his

shirt bosom, accompanied with strong contractions of the respiratory muscles, and apparent loss of consciousness. The struggle would last from four to six minutes, and the trance from forty to sixty minutes. For nearly three years his diarrhoea continued, then it began to improve, and finally got entirely well. His loss of weight was very great, partly due to his refusal to eat. He said he slept very little, complained of pain in his left chest. In the fourth year he began having paresis of the left leg; this weakness gradually increased to complete paralysis of the limb. He went on crutches long afterwards, and after he had been in this disabled condition for five years, careful examination failed to find a diseased organ or any evidence of organic disease. There was no muscular atrophy, and deep reflexes remained normal. In addition to the above his emotional and mental state confirmed the opinion of the functional character of his ailment.

Some ten years ago a suit for personal damages was brought in the circuit court of this county by a Miss Barnes. After two trials she recovered heavy damages. Before the trial came on a number of physicians were invited to visit and examine the complainant. Dr. McGannon and myself were among them. I am indebted to him for the following history of Miss Barnes, taken at our visit.

Miss Barnes was twenty-five years old, single, has five sisters and six brothers. Father died of phthisis; mother living; brothers and sisters living and well. Her health was good until 1894, when injured. Menstruation irregular, but up to April, 1894, had been regular; at this time did not appear. Appeared scantily for two days in May; in June occurred twice. Cannot remember how much at each time. In July was very profuse, lasting seven days, and was clotted. Since then has been regular, periods lasting seven days, except last month, when it occurred twice. On March 8, 1894, was injured at corner of Church and Summer, and at the time remembered nothing until she reached Broad Street. Buggy not damaged, except the dash; horse not hurt; drove herself home, to east side of river; that evening had a spell, which mother thought was nervous. The doctor was called next morning, fifteen hours after accident. Was then

seemingly unconscious. No injury to her person was found. Some hours after the doctor's visit she had a fit, and they thought she was dead. No bleeding at the mouth; mother says some froth. In September, 1894, some pieces of hat-pin came from the wrist, in October a piece from right nostril, and in November another from the knee, and on November 29 vomited a piece; others from the nose, from abdomen and both ankles, and one is now felt under the skin of the knee. At time of accident she had two large and eighteen smaller pins in her hat and hair; one of these was found afterwards. Reflexes were normal; right leg drawn up under thigh; she walked with crutches; right hand closed, with thumb inside; all easily straightened out. Anæmic and swarthy. Diagnosis, severe hysteria.

The allegations in the bill claimed that as she was passing a large pile of heavy iron girders, which partly occupied Summer Street during the construction of the Jackson building, one of them fell on her buggy, struck her insensible, broke up the hat-pins, and drove them into her brain; that the fragments finally worked their way out and appeared in different parts of the external surface. That in consequence of the blow her skull was fractured, and something over a year afterwards she had to have the skull trephined, because of paralysis of the left side. That she repeatedly had convulsions since the accident. *The truth*, as proved at the trial, is briefly that her buggy ran into the end of a girder, broke the dashboard, and she was not hit at all, but frightened. The fragments of pins which were taken from her were shown to the court. They were from an inch to an inch and a half long. They had undoubtedly been thrust under the skin willfully and designedly; probably the parts of the integument so used were insensible. A disc of bone removed from the right side of the skull, with the frontal suture traversing it, was also shown to the jury. She recovered from paralysis of the left side after operation, but as the point at which the disc was removed was a long way in front of the motor area for the leg, the good result could only have been through psychic channels. This patient was heard from one year ago, and was living and fully restored to health.

Very recently a young woman came here to consult a phy-

sician. It appears that in May last, on account of some periosteal trouble in the right hand, it was thought necessary to amputate about three inches above the wrist. She came because of great pain in the stump and entire arm to the shoulder, and also because of the peculiar condition of the skin of this amputated limb.

The physician who once attended her was along with her and stated that two years ago, when she was seventeen years old, he was called to see her at her home in a spell which was clearly an hysterical attack, and that a few weeks after when she recovered and attempted to walk she showed a tottering gait — abasia — astasia.— very characteristic of hysterical paraplegia. Through the courtesy of Drs. King and Wood I examined the arm of this patient. She appeared in good health, but emotional, and the eyes filled with tears readily. She affected great sensitiveness and dreaded my attempt to touch the affected integument. The discoloration was a mixture of reddish brown with paler dirty looking spots. What first struck me was that the alteration was on the surface and not in the skin. On closer examination I saw that it was not in the least like a cutaneous disease, but was a traumatism, I thought from the application of some acid, but Dr. Wood suggested that it was from the application of a hot piece of metal, which is doubtless correct. It was artistically done by her own hand and probably upon an integument where hysterical analgesia existed.

Allow us to recapitulate, in order that we may better emphasize some points in the differential diagnosis. The physician in framing a diagnosis should be well up in nervous disorders; for while many cases are easily recognized, some require caution and deliberation. A clinician would injure his reputation by declaring a case functional where a serious organic lesion existed. Then hysteria and organic brain lesion may co-exist and the symptoms of both must be considered. It helps much when trying to reach a conclusion in a difficult case, to first get a close personal acquaintance with your patient. Take time to make a quiet observation of her expression, manner, and drift of conversation, through which you may have insight into her emotional nature. Notice if she likes to recite her sufferings and symp-

toms, and whether she is in a state of serious apprehension of her condition, or is complacent and desires sympathy. The personal equation in this class of patients counts high.

It is also important to bear in mind when you suspect hysteria that organic diseases may also exist, which are apt to excite and accentuate the symptoms of the first. When you hear from relatives an account of so-called convulsive attacks, it will be difficult to decide as to whether it is epilepsy or hysterical seizures. If, however, you are present there should be no real difficulty. In epilepsy (grand mal), the coma is profound; the attack unexpected; the face is more flushed and congested; the conjugate deviations of the eyes more frightful. The *hysterical attacks* come with some preparation; the fall, if the person is on her feet, more gentle; the tongue is never bitten; no involuntary escape of feces or urine. When the epileptic sleeps off the first fit she or he gets up right away, retaining no recollection of what has passed. The hysteric arouses more gradually, looks around slyly and carefully, then takes to sobbing, or else drops into another spell. A remarkable and constant sequel to a functional seizure in the passing of a large quantity of clear urine of low specific gravity.

In the motor sphere, we have palsies and contractures. If these occur after a well-prounced crisis, the probability is that they are functional. In brain palsies the advent is more sudden and the loss of power more complete; in the hysteric the opposite, while in the latter it is often confined to a leg or forearm. From spinal disease it differs in not following the tract and distribution of a nerve. The flaccid nature of the paralysis, the absence of muscular atrophy, and the persistence of normal electrical actions, as well as that of the deep reflexes, should decide the diagnosis in favor of hysteria. The contractures of hysteria can be readily distinguished from those accompanying old brain lesions, as well as those from joint affections by the inhalation of ether, relaxation of contraction at once occurs in the former under narcosis.

Many neurologists refer to the similarity in the symptoms of multiple sclerosis, especially in its early stages, and the consequent difficulty in differentiation, from the functional neuroses. When convulsive attacks occur in the former, they are *epilepti-*

*form*, in the latter *hysteriod*. In the presence of visual defects, the optic disc is found atrophied in sclerosis, and normal in hysteria. No inequality of pupils, no strabismus or nystagmus in the functional. No alteration in the speech of the latter, syllabic in the former. The hemiplegia and paraplegia of hysteria is of the flaccid sort while in the other it is always spastic. Anæsthesia of the skin very common in the former, hysteria; seldom in the latter.

The general make-up of the psychic symptoms in neurasthenia ought to prevent confounding it with hysteria. The subjects of the first take a more serious aspect of their ailments, are more disposed to be melancholic, but have more self-control, no crying and sobbing, no globus or clonus. The etiology of the two will help to decide. The history of crises and the presence of stigmata are important points.

It should be remembered that hysteria is sometimes developed by neurasthenia and anæmia. That is, they are of the nature of proximate causes. After all, I think the real difficulty is seldom met with in coming to a correct discrimination between organic and functional disorders, provided painstaking examination is made. When you have made your diagnosis, and are fully convinced it is hysteria, it will be very often impossible, at least injudicious, to state the truth to the family. The laity cannot comprehend the nature of such disorders, and the honest clinician may lose the confidence of the family, as well as much filthy lucre, by stating his convictions.

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## DISEASES OF CHILDREN'S TEETH AND TREATMENT.\*

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BY W. C. GILLESPIE, D. D. S., OF NASHVILLE, TENN.

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The essayist has taken liberty to depart somewhat from strict adherence to the subject assigned by the Essay Committee, and will expand the latitude of the essay beyond what would be the limits of a discussion of the diseases to which the *teeth* of children are subject.

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\* Read at regular meeting of Nashville Academy of Medicine, Nov. 8, 1904.



The teeth themselves are subject to few changes, and a detail of operative procedure in restoring them to the performance of their functions would be of far less interest to physicians than to dentists.

The subject will be treated in the relation of dental pathology to that of pathological manifestations of contiguous and remote tissues and organs; and the term, "children's teeth" will be made to embrace not only the deciduous and temporary teeth, but apply to permanent teeth also, up to the age of nineteen or twenty. This paper will also take the form of an introductory chapter to a series to follow at various intervals, provided the Academy does not procure an injunction to prevent it.

The essayist is bold enough to take this step, not because of any feeling of peculiar fitness for such a task, nor from overweening confidence in his ability to intelligently present the case, but because of the conviction that *some* one should do more than is being done.

The development of dental science has been in an inverse order since its earliest inception in the ages of the remote past. Its progress has been the counterpart of beginning with the roof to build a house, and constructing the foundation last.

The first operations were the extraction of teeth to relieve pain, instead of preserving teeth to prevent pain. These teeth, through utter neglect, had become the source of intolerable discomfort. Later, in addition to relieving by extraction, an effort was made to save such teeth as had not been rendered totally beyond redemption by the ravages of decay. Next comes the substitution of artificial dentures to replace lost dental organs.

In all these instances the patient had reached a more or less mature age before seeking the dentist, and the teeth operated upon present a very considerable degree of carious disintegration, with accompanying pathological conditions of the dental pulp and adjacent soft tissues, often exciting serious complications in more remote organs. No attempt was made to *prevent* caries at the time it can most effectually be done—in childhood and early youth. Little attention was given to children's teeth until the ravages of caries produced severe pain and necessitated immediate action to obtain relief. Little or no effort whatever was made



to prevent pathological conditions arising, the entire object sought being restoration *after* the injury had been accomplished. *Prevention* came only as an after thought, inspired by viewing the wrecked and ruined condition of a being God Almighty had fashioned after his own image and generously provided with *two* sets of teeth to last throughout life, while only a *single* set of other organs were supplied to last the same length of time. Only of late years has a really intelligent effort been made to treat diseases of children's teeth, and as a general practice it yet falls woefully short of duty. And thus, while the superstructure of our professional achievement has reached a high degree of perfection, we are just beginning on the foundation.

In thus indicting my profession, I do not the less excuse the medical practitioner and the parents of the children, for their conduct has been equally reprehensible. Dentist, physician, and parent are guilty of sins of omission, from which the human race will reap suffering and unhappiness for generations yet to come, and the snaggle-toothed and toothless will stalk abroad in the universe, and in the dead hours of night the wail of the child with toothache will be heard in the land, as well "as the voice of the turtle."

Of the three responsible parties named, if one is to be censured more than another, it is the physician. The parent is guilty with mitigating circumstances. The parents grow up in ignorance themselves, and but few learn afterward until too late. The dentist rarely sees the child professionally until nothing but the root of the tooth is left, and that badly abscessed. Unless the child is enduring actual pain, the parent rarely seeks the dentist for preservation of the child's teeth, and when urged by the dentist to have this done, it is more often than otherwise regarded as merely a "speil" for more business.

The physician bears a different relation to the family from that of the dentist. The physician is called in to guide the tiny, helpless youngster along the narrow path that brings him out upon the strange, new world—the stage upon which he becomes an actor in the "Tragedy of Life," and the proud father and the grateful mother look upon that physician ever afterward as a kind of god-father to their child. The physician himself "points

with pride" to the fact that he officiated at that eventful time, when in after years the poor, little, helpless mite who involuntarily caused all that commotion that night, and who lived despite neglect and misguided affection, has climbed high upon the ladder of Fame. The physician has charge of the child from birth and is called to attend him whenever the ills to which he is heir befall him. Through the dangers that often accompany teething, the physician is constantly consulted. After first dentition is complete, the child is frequently seen by the physician and though the physician feels that he is conscientiously performing his duty toward the child as regards his general health, decay of the teeth is allowed to go on until acute suffering necessitates the services of the dentist. So, while carefully watching the child's liver, kidneys, brain, and general nervous system, the physician goes along heedlessly permitting to take place a condition of the dental organs which may eventually put all those organs out of business. It is a strange thing to a dentist that a physician can look into a patient's mouth and never see anything but the tongue. In the Scriptures we read of "an eye single to the glory of God," and among medical practitioners we find an analogy in "An eye single to the tongue."

Nor are physicians less observant of dental organs of the children they are called upon to treat, than of older patients. Many reputable, competent physicians, who are skilled in diagnosis and practical application of the science of their profession, have patients under constant observation for extended periods, and the whole time overlook a most deplorable condition of the teeth and gums, from which may be a constant flow of pus which, with imperfect mastication and insalivation of food, must necessarily impede the progress of cure of *any* pathological condition for which the patient is undergoing treatment. Hence it is as imperative that the physician become interested in the children's teeth, as it is for the dentist, and an understanding should be made by both physician and dentist of the influence of dental irritation in the manifestations of disease in the internal organs and tissues.

Will not attempt to outline any treatment plan, for that they are more capable of handling

than he, but will call your attention to the influence of dental irritation on various organs.

The first disturbance is observed when first dentition begins. This usually is about the fifth to seventh month after birth and extends to the twenty-seventh or thirtieth, when dentition or eruption is complete. A normal child, properly fed and cared for prior to and during dentition, will pass through that period of its existence with slight local and systemic disturbance. Teething is not of itself a dangerous process, though the rate of mortality is high during that period. The lack of uniform development of the child at that age renders it exceedingly susceptible to nervous impressions, and any pathological condition existing in any organ of the body must be greatly aggravated by difficult dentition and alarming symptoms become manifest. The preponderance of the nervous system in infancy renders it possible that a slight functional disorder will produce a profound impression upon some remote organ. That this is especially true of the dental organs is attributable to the fact that the teeth are supplied by branches of the fifth pair, or trifacial nerves, which are the largest of the cranial nerves, and the function and distribution of the trifacial is so complex that a slight irritation is capable of producing extensive results. At first, only slight symptoms may be present, and if the general systemic condition is good, that will be the extent of it, but if any pathology or functional disturbance exists, the additional dental irritation may be sufficient to produce alarming and even fatal results.

When the eruption or elongation of a tooth is not proportional to the rate of absorption of superimposed tissues, great nervous disturbance may arise, paralysis and death not being without the range of possibilities. This is due to the pressure of the root ends upon the branch given off by the branches of the maxillary division of the fifth pair supplying the teeth, and the irritation being readily transmitted to the brain centers. Premature eruption of teeth gives rise to more excitation and inflammatory conditions than delayed eruptions, because the older the child the nearer uniformity of developmental equilibrium, and premature eruption is itself a manifestation of nervous disturbance or undue irritation of some nature. Difficult dentition is

always accompanied by intestinal disorders, convulsions are frequent, the child nervous and excitable, and an increased susceptibility to all infantile disorders is present.

Passing now to a later stage of child life, we will take up the decay of the temporary teeth. This is looked upon by parents and many physicians as a matter of small importance, usually dismissed with the remark: "O well, it doesn't matter much, they have to be lost anyway." No greater sin against the child could thus thoughtlessly be committed.

It is just as essential for those teeth to remain in position in the arch until the proper time for removal as it is for them to be placed there by nature in the beginning; and it is just as important that they should be kept in condition to fully perform their normal function of mastication and developmental guides. The child's health and growth depend primarily upon perfect digestion and nutrition. To render this possible, nature provides the child with a suitable set of teeth which conform in size and shape to the dimensions of the maxillary bones and to the function these teeth have to perform. Under normal conditions these teeth are developed and erupted in the order and number best suited to the child's requirements. As the digestive organs become capable of performing their function, the diet should be regulated accordingly and more solid foods given with due regard for the upbuilding of the tissues. Such food-stuffs need mastication and insalivation to properly prepare them for digestion.

No matter how well the digestive organs are prepared for their work, unless the bolus of food is masticated and insalivated, just that far will digestion be imperfect. For a brief time they may rise equal to the emergency, but soon or late the strain of over-exertion must prove disastrous. You understand well enough the evils of imperfect digestion to render unnecessary special comment upon that, and the object in stating to you facts understood equally as well, is but to emphasize *that* phase of the importance of saving the temporary teeth.

Another point bearing upon the correction of decay of the temporary teeth is the proneness of children to form habits in early life that last through a life time. When the child has a

sensitive or abscessed tooth, or sharp jagged edges of cavities or roots, violent paroxysms of pain are often caused during mastication. The child soon learns that by bolting the food in chunks, hunger may be appeased, and pain avoided. The habit early formed as a necessary expedient becomes fixed and in due time a "Rockefeller" stomach is developed on ordinary diet. That this habit of bolting food can be and is formed, is an indisputable fact, and it induces a large per cent. of the digestive disorders that become a menace to the life and happiness of the victim, and renders more or less futile treatment for cure of conditions independently developed.

As an illustration of the effect of this forming of habit in early life, from a necessity to avoid pain, a case is cited within the personal knowledge of the essayist of a boy eight or ten years of age who became the possessor of a stone-bruise on his heel, and even after he reached manhood continued to limp and walk on the ball of his foot through habit thus formed.

Imperfect digestion in turn stimulates the attack and progress of caries. This is done through acid reaction of oral fluids, and thus we see a circle completed, caries being a factor producing derangement of digestion and being itself produced by it.

Another phase of the question of necessity for eradicating decay of temporary teeth is that upon their preservation depends uniformity of development of the maxillary bones, and this necessarily influences the development of all the facial bones. Going a step further it might not be beyond the range of possibilities, that even the character of the child may directly be influenced. Lack of development of the maxillary gives a weakened expression to the individual — a retreating chin, a weak mouth, improperly developed malar bones, "dish face," etc., which may play an important part in shaping the course of the individual's life through impressions created upon those with whom he comes in contact. This of course would not follow as the inevitable result of premature loss of temporary teeth, but such loss will surely bring about some degree of these baneful results.

This much, however, may be said with certainty: Through premature loss of the temporary teeth, modifications of normal developmental processes of the facial bones will take place that

may amount to anything from a slight irregularity of the features to the wreck and ruin of the victim's health and happiness.

With the arrest of the development of each bone or organ comes impairment of function, with relative loss to the entire system; its increased susceptibility to pathological change, and the influence exerted by such arrested development in modifying perfect development of other structures.

With arrested development of the superior maxillary bones comes malformations of articular bones, which gives rise to conditions producing obstruction to nasal passages, and deafness mechanically as well as through pathological growth. These malformations cannot exist without at least an increased susceptibility to disease, even though such disease does not develop. Arrested development of the maxillary bones induces irregularity of position of permanent teeth in the dental arch. Again, we find the circle completed, and decay produced in permanent teeth by favorable conditions arising from such irregularity.

Irregularity of teeth produces mal-occlusion, and this in turn modifies normal development of the maxillary bones and aggravates any congenital malformation, and we have more or less serious pathology again excited.

So far the essay has touched only indirectly on inflammatory conditions from carious teeth, and the communication of such inflammation of contiguous tissues to more remote tissues, but that must be left for a later essay. The import of this essay is, that it be introductory and call more especial attention to the importance of *saving* childrens' teeth, and to more thoroughly impress upon the physician the necessity for his co-operation with the dentist in this all important work.

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## HEPATIC INSUFFICIENCY.

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BY HUBERT RICHARDSON, M. D., OF BALTIMORE, MD.

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No organ is of more importance to the general metabolism and consequent nutrition of the body than the liver, through it passes the whole of the nutrition and not only has it to change the chemical form of food products, but it has also to arrest,

transform, and eliminate toxic products and soluble poisons taken in with the food, and also to act as a storehouse for nutritional substances. From its multiplicity of functions and the artificial conditions under which we live, it is subject to severe strains upon its powers, causing it to be overtaxed, thereby becoming deranged and unable to functionate perfectly, more than any other organ of the body. One of the most important factors in keeping an organ in health is that its elimination of the waste products of metabolism should be as perfect as possible, for this purpose the liver possesses a special secretion, the bile; should the chemical composition of the bile be pathological or the quantity deficient, it is evident that the elimination will be interfered with, and it is therefore of great importance that both the quantity and quality of the bile should be maintained.

The quantity of the bile secreted by the liver in twenty-four hours is about 800 to 900 grams, with about 15 to 16 grams of solid matter, about 10 grams of which are bile salts, principally glycocholate of soda, the remainder of the solids being excretory matter, viz., bile pigments, cholesterin, etc.

The so-called cholagogues of the *materia medica* have time and again been found to have no effect in producing an increased flow of bile, in cases with biliary fistula. Huppert (*Arch. F. Heilkunde*, 1896) and Gosenberg (*Arch. f. d. ges. physiol.*, 1890) have conclusively shown that the bile salts are the only substances which will increase the flow of the bile. Schaefer, in his textbook of physiology, 1898, p. 563, says: "They (the bile salts) appear to be the only substances which produce this result, and since the bile salts are the most abundant solids of the bile, it seems fairly certain that they are absorbed and re-excreted from the blood by the liver." Pfaff and Balch (*Journal of Experimental Medicine*, 1897) show that human bile, ox bile, and bile salts have a marked cholagogue action and also that during the administration of bile the bowels moved without medication, the stools decreased in bulk but increased in consistency and color, and conclude by stating that the bile salts may be useful in certain cases of constipation, and when it is desired to increase the absorption of fat. Dr. Eliot P. Joslin (*Journal of Experimental Medicine*, 1901) in a most interesting paper on a case with biliary



fistula and gall stones, in which bile was administered, comes to the following conclusions: That the administration of bile increases the digestion of fat (in his case 50 per cent.); that the digestion of nitrogenous food was improved; that ox bile is a cholagogue.

The active principle, so to speak, is the bile salts, and it is therefore better to give them in a pure form than with the addition of the pigments and cholesterin and other impurities contained in the *Fel Bovis* of the *materia medica*. The *Fel Bovis purificatum* is little better, the purification method being hardly worthy the name, and very crude.

Gall stones are of two kinds, pigment and cholesterin, both of which are formed by the precipitation of their constituents owing to an insufficiency of their normal solvent, the bile salts. Cholesterin is in the laboratory a most intractable substance, being soluble only in ether and boiling alcohol of the ordinary solvents, neither of which it is therapeutically possible to bring into the gall bladder or into the general circulation in sufficient quantities to be of any use. Pigments are also soluble with difficulty, and it therefore follows that the only practical solvent is that provided by nature, the bile salts, which can be administered by the mouth, passing through the liver into the bile. From the above considerations it seems rational to try their effects upon the patients suffering from hepatic colic. Dr. Todd of Baltimore had a patient who for years had suffered every three or four months from hepatic colic and had been under all the various traditional treatments of the text-books without effect. He commenced taking the glycocholate of soda extracted from ox bile in November, 1898, and up to the present time has had no return of the trouble. Dr. H. Burton Stevenson of Rider, who had three cases of hepatic colic in his practice, tells me that all of them have been free from attacks since the treatment commenced.

It was not, however, from hepatic colic that the writer commenced the use of glycocholate of soda, though among the insane, autopsies show that about twelve per cent. have gall stones and twenty per cent. disease of the gall bladder, but as an hepatic stimulant. Any one accustomed to the insane will have noted the dirty brownish discoloration of the skin, often associated



with a slight yellowishness of the eyeball, while on urinary analysis traces and sometimes more than traces of bile pigment can be detected, pointing to a deficient elimination of bile pigment by the liver, the presence of an excess of urinary pigments, urosin, ethereal sulphates, indol, and increased proportion of neutral sulphur as well as clinical symptoms pointing to an hepatic insufficiency, which made it necessary to look for some method which would stimulate the liver to healthy and complete action. Insanity being a physical disease with mental symptoms, it is of importance that every organ of the body should be put into as healthy a condition as possible, if mental improvement is to be obtained. It was for this purpose that the writer suggested the use of glycocholate of soda to Dr. Charles G Hill, the physician-in-chief of Mount Hope Retreat, and the results have exceeded our expectations. Under the influence of the bile salts the muddy icteroid complexions clear up, many of the so-called liver-spots disappear and the general condition and nutrition of the patients improve.

A defective excretion of bile by the liver may produce cirrhosis. Dr. Mason (*British Medical Journal*, 1898) tied up the left gall duct in a dog and found after six months a marked cirrhosis of the left lobe of the liver. Dr. Mills (*British Medical Journal*, 1901) records a case of hepatic cirrhosis caused by obstruction of the bile ducts. In cases of chronic alcoholism and gastritis in which the formation of butyric and other acids takes place in the stomach, they produce a cirrhosis of the liver, if not rapidly eliminated. Boix has shown experimentally that it is not alcohol *per se* that produces cirrhosis, but the fatty acids which are produced in the gastritis consequent upon the effect of alcohol on the stomach. Exner (*Deutsche med. Wochenschrift*, 1898) found 4 per cent. of his cases of glycosuria had gall stones, and Zinn (*Centralbl. f. innere Med.*, 1900) found 2 per cent. Many cases of glycosuria are hepatic in their origin and are curable by a not very strict diet, with the substitution of fats, as far as possible, for starch, and glycocholate of soda to assist in the assimilation of the fat. We have had four cases in Mount Hope Retreat diagnosed as hepatic glycosuria, two of them with gangrene, which have been cured by this treatment, viz.: An ordinary

diabetic diet, but allowing three slices of bread a day, also all kinds of fruits and vegetables except potatoes, beets, and grapes, with as much fat in the shape of butter, cream, or oil as the patient would take. The medication consisted in  $2\frac{1}{2}$  grains of glycocholate of soda to increase the absorption of the fat and to stimulate the liver, and  $2\frac{1}{2}$  grains of thyroid (Armour's) t. i. d. to increase oxidation.

The glycocholate of soda was supplied by Messrs Hynson and Westcott, of Baltimore, and we have usually given it in five-grain doses, though in one case we gave 15 grs. t. i. d. for some time with marked benefit. As the bile salts are cumulative, being reabsorbed by the intestine, it is not necessary to keep up the dosage for any length of time; in the cases of hepatic colic the patients take about two drams per month. From the writer's experience, and that of other physicians, the glycocholate of soda is useful in many cases in which other remedies fail, and is better than Fel Bovis on account of its being more pure, and is a useful rational hepatic stimulant.

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ANEMIA IN CHILDREN.—Among other causes of anemia G. Carrière (*Le Nord Médical*, October 15, 1903) mentions overfeeding. An excess of alimentation causes gastric stasis and intestinal autointoxication, and reabsorption of the intestinal poisons destroy the red globules and cause anemia. The author has observed three cases in which overfed children were restored to health simply by moderating their diet, without any other treatment. Anemia in children may also be caused by chilling, which is not surprising, as the writer has proved by experimentation that cold induces a marked destruction of red corpuscles. Overtaxing the physical or mental strength is another frequent cause of anemia. The author recommends the usual hygienic measures, and in the way of medication praises the cacodylate of sodium. It is best to use it for a while, beginning with three-drop doses twice a day and increasing a drop at a dose until ten drops are taken twice daily. This may be kept up for eight days, diminishing drop by drop until the primary dosage is reached, and a rest of ten days is then taken. Iron treatment may be instituted later.—*Medical Record*.

## *Abstracts.*

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### THE EFFECT OF COLLARGOLUM ON THE BACTERIA THAT ACCOMPANY THE TUBERCLE BACILLUS.

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BY DR. MAX BEHR, ASSISTANT AT KOEHLER'S HOLSTERHAUSEN  
SANATORIUM, WERDEN ON THE RUHR, GERMANY.

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The extensive literature on the use of collargolum in the most varied infectious processes incited Behr to try it in mixed phthisis infection. He used the rectal method lately recommended by Loebl, and simultaneously administered it per os. A tablespoonful of a 1% solution was exhibited by mouth twice daily in coffee, tea, or cocoa; per rectum 1 oz. of 1% solution was given daily. Defecation and a cleansing irrigation preceded every injection. Thus every patient received about  $7\frac{1}{2}$  grains of the silver per day.

The treatment was given to those phthisis patients in whose sputum repeated careful examination had demonstrated an abundance of streptococci and staphylococci. Koch and his followers believe that mixed infection is present in the majority of phthisis cases, and that the pus-producing cocci are more injurious even than the tubercle bacilli, causing the tissue destruction in the lungs; while the Leyden school considers it unimportant. Behr attacks the question from the practical standpoint, observing what effect the treatment had on the cocci.

He records 14 cases, of which 11 had phthisis in the first and 3 in the second stage. Collargolum was given for an average of 100 days. The expectoration diminished or disappeared in 10 cases; the number of cocci was decreased in 8 cases. Three patients discontinued the treatment on account of anorexia, etc. The general results, especially as shown in the increase of weight, were very satisfactory.

Behr does not agree with Loebl that 14 days is the limit of time for the enemata. In fact, in cases in which there were by-effects at first, the remedy was well borne when persisted in.

In one case of uncertain diagnosis the sputum contained enor-

mous masses of pus cocci, and Behr was astonished at the result of 4 weeks of collargolum treatment. The amount of cocci greatly diminished, and the general condition markedly improved. He therefore also recommends a trial of the drug in non-tubercular suppurative pulmonary processes. His observations have not been extensive enough to enable him to affirm with certainty that it combats the tuberculosis itself; but it does influence the pus organisms that so often accompany the tubercle bacilli.

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## *Editorial.*

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### OUR TWENTY-SIXTH VOLUME.

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This number completes our work for the year and closes our twenty-sixth volume. With a satisfaction of having done our duty, and discharged to the full the promises we have made, THE SOUTHERN PRACTITIONER still lives, maintaining, as it has always maintained throughout its successful career, the character of an independent medical and surgical journal, earnestly endeavoring through all these years to elevate medicine, to diffuse professional intelligence, and to present the latest movements of progress in our noble and time-honored calling. We have steadily increased its pages as its clientele has been extended, and as we have done in the past, so are we willing to continue in the future as long as life and ability are granted us.

We can glance with a feeling of just pride and self-satisfaction at the twenty-six annual volumes. Beginning in 1879 with thirty-two pages each month, the number has been doubled, these pages from then until now containing a full, fair, and comprehensive statement of the accepted facts, the outcome of the advances and progress in our science and art. This printed record of the past shows how we have discharged our duty assumed over a quarter of a century ago—our satisfactory and steadily increased patronage proves it to have been appreciated. We have on our subscription lists names that have been there continuously since 1879, and while a large majority of our esteemed friends and patrons of that day have passed over and into the "beyond," others have stepped in to not only fill up the gaps made by inexorable time, but to greatly increase the number. Since our initial number children have been born, passed through childhood, attained manhood, and becoming active, earnest, and reputable members of our profession, are warm and sincere friends and supporters of the journal. That its monthly visits to the old, middle aged, and young have been appreciated is

well attested not only by our increased subscription lists, but by many personal letters and expressions of approval and commendation, which are a source of greatest gratification, and an assurance that our labor has not been in vain.

Of our twenty-six volumes we regard this one as the best, not only in the contents of its pages, but in its mechanical execution. Yet, not content with this, we do not propose to stop here, and take pleasure in stating that we have entered into a new contract with our publishers and printers for better paper for the next volume. Their work for the past year we can most heartily commend. The year now closing finds us with a larger, and with the correspondence during the year as a test, a more appreciative clientele than any that have preceded. This appreciation we will endeavor to perpetuate by giving increased attention and most earnest devotion to our editorial duties, feeling confident and assured that as we may be personally benefited thereby, yet it is for others; and that we of all others can appropriate the beautiful words of the gifted Payson, "Not for ourselves, but for others, is the grand law of nature; not for itself, but for others, does the sun dispense its rays; not for themselves, but for others, do the clouds distill their streams; not for herself, but for others, does the earth unfold her treasures; not for themselves, but for others, do the trees produce their fruits, or the flowers diffuse their fragrance and display their varied hues. So, not for himself alone, but for others, are the blessings of heaven bestowed upon man."

The year now closing has been one of unusual prosperity to all throughout this vast country, and our own Southland has had its full share. At peace with all the world, with bountiful harvests, a happy and prosperous people, freedom from devastating epidemics, the good year 1904 has been peculiarly beneficent and enjoyable. While we have just passed through a regular quadrennial political turmoil, and everything did not go just as we would have wished, yet there is no cause or ground for worry even in this. The American people are going to keep on doing business at the same old stand and in the usual way. The retention of Mr. Roosevelt as President, with all his "strenuosity," is not going to carry the country "to the demnition bow-wows." He is not going to plunge the people into trouble, turmoil, and strife in a personal desire for the spectacular. He could not if he so desired, and we do not believe that he will desire it. We may for the time feel regret that it did not come out different, but as it did not, let us make the best of it. There is one great big congratulation we may take to our hearts. We have such a grand country, and it is so prosperous, that no matter what party is in power, nor who is at the head of the nation, the watchman of both day and night, if we but do our duty, will meet with no interruption in his cry that "All is well with the Republic." Yes, "all is well." The United States

of America, prosperous at home, respected abroad, and maintaining domestic tranquility, can and will remain a beacon light and a model for all civilized and enlightened nations.

Rev. Sam Jones, of Georgia, has said many good things in his day and time, but nothing more *apropos* than the following we find in a recent Atlanta paper:—

“Teddy is in the saddle for four years more (D. V.) and the Democrats are afoot, so to speak, but walking is good and much cheaper than riding, though it is not so expeditious.”

Dropping into a mood of philosophic reflection, Mr. Jones says:—

“After all, an election is but an expression of the choice of the people, and the majority in this country rules, although Teddy got about a two-thirds majority. I have met no one who had on mourning or seemed to be in sackcloth and ashes. Ten-cent cotton ‘soothes our sorrows, heals our wounds, and drives away our cares.’ The South is financially and commercially ‘in the saddle,’ and although we lost politically, we are ahead in a thousand ways. Cotton to burn, corn to sell, sorghum and hay to let, debts paid, and money in the bank. We have got a heap to shout over. We can thank God and take courage. Georgia and every Southern State has as good a President as Pennsylvania, or New York, or Michigan.”

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### SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

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The seventeenth annual session will be held in Birmingham, Ala., December 13, 14, and 15. The following is the very interesting, intellectual menu as furnished by the Secretary, Dr. W. D. Haggard, of Nashville, Tenn. Reduced rates on all railroads of the Southern Passenger Association.

Presidential Address. Dr. Floyd W. McRae, Atlanta, Ga.

Address of Presentation of Davis Monument. Dr. C. M. Rosser, Dallas, Texas.

Address of Acceptance on Behalf of State of Alabama. Gov. R. M. Cunningham, M. D.

Address of Acceptance on Behalf of the City of Birmingham. Hon. W. M. Drennan.

Gall Stones in the Ampulla Vater. Dr. A. H. Furguson, Chicago, Ill.

A Method of Uniting Intestines of Very Small or Unequal Calibre. Dr. J. Shelton Horsley, Richmond, Va.

Enterostomy. Dr. J. W. Long, Greensboro, N. C.

The Treatment of Fecal Fistula. Dr. Stuart McGuire, Richmond, Va.

Intestinal Obstruction. Dr. D. F. Talley, Birmingham, Ala.

**The Abuse of Purgatives Before and After Abdominal Section.** Dr. I. S. Stone, Washington City, District of Columbia.

**Observations Upon the Aseptic Technic of Abdominal and Pelvic Surgery.** Dr. Henry T. Byford, Chicago, Ill.

**The Employment of Celluloid Plates for Covering Defects in the Skull.** Dr. W. Perrin Nicholson, Atlanta, Ga.

**On the Sterilization of Cutting Instruments.** Dr. H. A. Royster,, Raleigh, N. C.

**When Shall We Resect in Tuberculous Disease of Joints?** Dr. E. C. Caldwell, Cincinnati, O.

**The Clinical Consideration of Tumors.** Dr. W. F. Westmoreland, Atlanta, Ga.

**Personal Experience in the Surgical Treatment of Cancer of the Cæcum.** Dr. G. Wiley Broome, St. Louis, Mo.

**Cases in Which Early Diagnosis of Cancer of the Body of the Uterus was Made.** Dr. Rufus B. Hall, Cincinnati, O.

**Final Results in X-Ray Treatment of Malignant Tumors.** Dr. William B. Coley, New York City.

**Fibroid Degeneration of the Uterus after Ablation of the Appendages.** Dr. J. Wesley Bovee, Washington City, District of Columbia.

**A Contribution to the Origin of Adeno-Myoma of the Uterus.** Dr. J. Whitridge Williams, Baltimore, Maryland.

**Alexander's Operation.** Dr. Charles P. Noble, Philadelphia, Pa.

**Effect of Suspensio Uteri on Subsequent Pregnancy and Labor.** Dr. Joseph Taber Johnson, Washington City, District of Columbia.

**Surgical Treatment of Goitres.** Dr. G. W. Crile, Cleveland, Ohio.

**The Management of Acute Perforative Peritonitis.** Dr. J. Garland Sherrill, Louisville, Kentucky.

**Some Further Advances in Renal Surgery.** Dr. John B. Murphy, Chicago, Illinois.

**Report of a Case of Rupture of the Diaphragm** Dr. George S. Brown, Birmingham, Alabama.

**Typhoid Fever and Appendicitis.** Dr. J. C. Oliver, Cincinnati, Ohio.

**Vaginal Cæsarean Section, Report of a Case.** Dr. C. Jeff Miller, New Orleans, Louisiana.

**An Unusual Case of Cæsarean Section: Double Vagina, Double Uterus; Pregnancy in One Uterus, Fibroid Preventing Delivery in the Other.** Dr. Geo. Ben Johnston, Richmond, Virginia.

**Obliteration of Stomach by Caustic.** Dr. S. J. Mixter, Boston, Massachusetts.

(1) **Vesical Diverticula; Report of Four Cases Requiring Operation.**

(2) **The Ultimate Results Obtained by Conservative Perineal Prostatectomy in Seventy-five Cases.** Dr. Hugh Young, Baltimore Maryland.

**A Typical Case of Tubercular Peritonitis.** Dr. W. P. Manton, Detroit, Michigan.

Pelvic Floor Repairs During the Menopause. Dr. Joseph Price, Philadelphia, Pennsylvania.

Pelvic Inflammation: A Discussion of Some Moot Questions Relating Thereto. Dr. L. H. Dunning, Indianapolis, Indiana.

Hematoma of the Ovary. Dr. Magnus A. Tate, Cincinnati, Ohio.  
Tracheotomy for Gunshot Wound of the Trachea. Dr. J. McFadden Gaston, Atlanta, Georgia.

Stypticin in Uterine Bleeding. Dr. H. J. Boldt, New York City.

(1) Encephalo-Meningocele. (2) An Easy Method of Instituting Peritoneal Drainage Gauze through the Cul-de-sac. Dr. W. D. Haggard, Nashville, Tenn.

Title Not Announced. Dr. C. H. Mayo, Rochester, Minnesota.

Title Not Announced. Dr. M. H. Richardson, Boston, Massachusetts

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CRANIO-MUSCULAR ORIGINS OF BRAIN AND MIND, by Philip H. Erbes, is a book which proceeds from the *unignorable evolution bases*, and yields a new guide for the successful treatment of the multiplying *nervous and mental disturbances*. Illustrated, cloth binding. Price, \$1.20, postage 10 cents. For sale at booksellers, or *The Promethean Publisher*, 622 North Rockwell St., Chicago, Ill.

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#### SPECIAL DIRECTIONS FOR USE OF THE K. & O. BERMINGHAM NASAL DOUCHE.

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One of the objects in the application of Glyco-Thymoline (Kress) to the nasal cavity is to retain it in direct contact with the membrane for at least two minutes; this can be done very simply and effectively, as follows:—

Put into the douche one or two teaspoonfuls of Glyco-Thymoline (Kress), filling it with warm water (never use cold). With the index finger over the inlet control the flow, insert the nozzle into the nostril, and hold the head well back. While allowing the solution to run into



the nose, breathe through the mouth (pant, as it were); this closes up the passage into the throat, and enables you to fill the entire nasal cavity. As soon as it is full, take the douche away, pinch the nostrils together, and throw the head well forward; hold the solution in the nasal cavity for a couple of minutes, and repeat in the other nostril. Clear the head gently to avoid forcing products of inflammation into the eustachian tubes, as the Glyco-Thymoline (Kress) loosens up all the catarrhal crusts.

Do not blow the nose until you have thoroughly cleared the nose and throat.

If the catarrhal condition effects the throat, gargle with one or two teaspoonfuls of Glyco-Thymoline (Kress) diluted with a tablespoonful of hot water.

**THE LOCAL TREATMENT OF ERYSIPELAS WITH ACETOZONE.**—I had an ugly case of facial erysipelas in a woman of about thirty-eight years. I used as a local application, to begin with, a saturated solution of boric acid, and depended largely upon tincture ferric chloride as an internal remedy. I got the attack under control, and supposed I would have no further trouble, but all at once the disease began to spread over the scalp. The usual remedies did no good. I thought that if Acetozone was the germ destroyer it was represented to be, it should be of use to me. So I made a solution of fifteen grains to two pints of water, and used it freely on the scalp. I obtained results at once, and in twenty-four hours the disease had abated.

J. KNOWLES, M. D.

*Logan, Iowa.*

**ELONGATION OF THE UVULA.**—As a gargle in sore throat or elongation of the uvula, Kennedy's Dark Pinus Canadensis has very general endorsement, the usual proportion being teaspoonful to glass of water.

**THE PSYCHOLOGICAL DEPRESSIONS** and neuralgias so common in the period following a debauch are lessened or disappear altogether by the use of Celerina.

**EVERY PHYSICIAN KNOWS:** In the *North American Practitioner*, under the head of "Intestinal Antisepsis," reported by Dr. Pettingill, of New York City, we find some excellent experiences, and from which the following is selected:—

"Every physician knows full well the advantages to be derived from the use of antikamnia in very many diseases, but a number of them are still lacking a knowledge of the fact that antikamnia in combination with

various remedies, has a peculiarly happy effect; particularly is this the case when combined with salol. Salol is a most valuable remedy in many affections; and its usefulness seems to be enhanced by combining it with antikamnia. The rheumatoid conditions so often seen in various manifestations are wonderfully relieved by the use of this combination. After fevers, inflammations, etc., there frequently remain various painful and annoying conditions, which may continue, namely: the severe headaches which occur after meningitis, a 'stitch in the side' following pleurisy, the precordial pain of pericarditis, and the painful stiffness of the joints which remain after a rheumatic attack—all these conditions are relieved by this combination called 'Antikamnia and Salol Tablets,' containing  $2\frac{1}{2}$  grains each of antikamnia and of salol, and the dose of which is one or two every two or three hours. They are also recommended highly in the treatment of cases of both acute and chronic cystitis. The pain and burning is relieved to a marked degree. Salol makes the uric acid and clears it up. This remedy is a reliable one in the treatment of diarrhoea, entero colitis, dysentery, etc. In dysentery, where there are bloody, slimy discharges, with tormina and tenesmus, a good dose of sulphate of magnesia, followed by two antikamnia and salol tablets every three hours, will give results that are gratifying."

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ARMOUR & COMPANY offer Suprarenalin Triturates, which will be found very serviceable by physicians, as they supply the active principle of the suprarenal substance in convenient form.

The Suprarenalin Triturates dissolve readily in hot or cold water; each contains a sufficient quantity of Suprarenalin to make fifteen minims of 1:1000 solution.

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LISTERINE DERMATIC SOAP is an exceptionally meritorious article which will, we believe, be extensively prescribed by physicians for use in the treatment of diseases of the skin, as the antiseptic and detergent properties of Listerine "Dermatic" Soap prove beneficial in the treatment of the various cutaneous inflammations and eruptions, in combating all vegetable and animal parasitic diseases, in diseases of the sudoriparous and sebaceous glands and hair follicles, as well as for the relief of excessive and offensive perspiration.

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SOME ADVANTAGES OF COCA IN TYPHOID FEVER.—Our readers who are familiar with the therapeutic resources of Coca are aware of the many possibilities for its advantageous employment in the treatment of typhoid fever, not merely in convalescence, but throughout the course of the disease.

As a stimulant before the bath we prefer to give a wineglassful of Vin Mariani in eight or ten ounces of water at from 65 deg. F. to 70 deg. F. Coca, thus copiously diluted with water, augments the secretions and purifies the juices of the body, and also aids the liver, kidneys, and skin to eliminate the toxins to which the high temperature of typhoid is due. Besides promoting diuresis, Coca prevents constipation, which is such an annoying symptom. When drinking is repugnant, the remedy may advantageously be employed by enema, always with the full amount of water indicated.

When it is desired to strengthen the heart, a wineglassful of Vin Mariani may be given clear, without water, or if the mild alcoholic influence is not desired, give two teaspoonfuls of the Mariani in four ounces of hot water. Coca is preferable to strychnine as a heart tonic, and more desirable to use than digitalis; it acts as a food to the muscular tissue, and at the same time has a purifying influence on the blood.

In convalescence a wineglassful of Vin Mariani may well replace all spirituous stimulants, and will hasten recovery.—*The Coca Leaf*, March, 1903.

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SANMETTO IN CYSTITIS.—I used a bottle of Sanmetto in a severe case of acute cystitis. The result was all that could be desired. It relieved the patient in a few days. I shall continue to prescribe Sanmetto in such cases as it is applicable.

H. S. CROCKETT, M. D.

*Wilmore, Ky.*

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SANMETTO IN CYSTITIS.—I used Sanmetto in a case of chronic cystitis, with most satisfactory results. The case is cured. It is a most charming preparation, if I am to judge its merits by this case.

*Bryson, S. C.*

R. H. BRYSON, M. D.

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HYDRAGOGIN—THE MOST POWERFUL DIURETIC.—A dark brownish liquid, which foams readily on being shaken on account of the Oxy-saponin which it contains. Oxysaponin, a glucoside like Saponin, is a gray amorphous powder with a pungent. irritating odor, is sternutatory and has a somewhat flat taste.

Indicated in the various forms of dropsy and as a cardiac tonic.

Hydragogin is a purely vegetable diuretic, containing Tincture of Digitalis 1.5 parts, Tincture of Strophanthus 2.5 parts, Scillipicrin and Scillitoxin, the active principles of scilla maritima, and 0.5 part Oxy-saponin. The well-known diuretic action of the first four remedies is increased many times by the addition of the Oxysaponin, which is an extract from herniaria glabra. The preparation causes the most intense diuresis, without any unpleasant by-effects. Of course, patients with individual peculiarities may, after some time, complain of malaise, weak-

ness, anorexia, or aversion to the drops, and in these cases it may be well to discontinue the drug, and, after a short time, to begin again with smaller doses. Signs of irritation of the kidneys, which are so frequently caused by other diuretics, have never followed the administration of Hydragogin, although the drug has been used very extensively, and numerous hospital reports, and some of the most prominent clinicians of this country testify to its efficacy even in cases where all other diuretics failed.

Hydragogin is also a most reliable cardiac tonic, and in 10 to 12-drop doses, three or four times a day, will often cause the disappearance of attacks of cardiac asthma for days or weeks, and, in favorable cases, even for months.

Dose: 7 to 10 to 15 drops every three or four hours, in a tumblerful of some indifferent thermal water, or in sugar water; children in proportion.

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SCOTT'S EMULSION is a scientific pharmaceutical preparation, the medicinal ingredients of which are pure cod liver oil, with hypophosphites of lime and soda and glycerine. In this preparation the oil has been artificially digested by mechanical processes, thus preparing it for immediate absorption into the circulating fluid, and supplying what deficient digestive ferments fail to supply. The utility of this expedient in the dietetic management of many morbid states has received the approval of high authority.

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ANASARCIN is beneficial not only in dropsies, but in Exophthalmic Goiter.

It restores the natural balance between the arterial and venous systems, stimulates the heart, equalizes the circulation, promotes absorption of effused serum without increasing the debility of the patient or interfering with nutrition by producing loss of appetite.

"As a remedy for all dropsical conditions it has no equal.

"Abdominal ascites is relieved promptly, and even in those extreme cases where the dropsy had already crowded the heart, the results were magical.

LYMAN M. BECKES, M. D.

*Vincennes, Ind."*

"I am most sanguine in assuring the medical fraternity of the efficiency of Anasarcin as a heart tonic, and prompt, safe, and sure agent for the immediate removal of any dropsical effusion, and by natural channels.

L. V. HARBAUGH, M. D.

*Old Town, Md."*

Anasarcin combines the active principles of Oxydendron Arboreum, Sambucus Canadensis, and Urginea Scilla. An unequalled remedy in dropsies of Cardiac, Renal or Hepatic origin.

PANOPEPTON is the perfect food in typhoid fever.

It presents complete nourishment in a perfectly soluble and freely assimilable form. It is ready for use, acceptable to the patient, immediate in its reviving and restoring effects.

It imparts not only stimulus but strength, the strength of perfect nutrition.

There is a record of many cases of typhoid fever in which Panopepton was the only food given throughout the entire course of the fever and well into convalescence, and in the memoranda it is noted that the patients were well sustained; lost little flesh; passed the crisis easily; convalesced quickly and without complications.

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WAYNE'S DIURETIC ELIXIR is the best and safest in the treatment of Urinary Calculus, Gout, Rheumatism, Bright's Disease, Diabetes, Cystitis, Hæmaturia, Albuminuria, and vesical irritations generally.

Dr. Chas. Kelly Gardner, of West Virginia, in a recent letter, writes:—

"I anticipate as positive results when administering it as I do from Opium for pain or Quinine for intermittents."

It has been in constant use by the best physicians for twenty-two years. Try it, doctor. Allow no substitution.

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MESSRS. WM. R. WARNER & Co. have been honored by the highest award, the Grand Prize, for pharmaceutical preparations at the Louisiana Purchase Exposition at St. Louis.

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AN EXPERIENCE WITH PEPTENZYME. I have recently had occasion to prescribe Peptenzyme in a case of vomiting of pregnancy in a woman, age 35, a primipara. She suffered intensely from nausea immediately after eating, having been unable to retain scarcely any food for nearly three weeks. Various digestive compositions were employed without the least benefit, some even seeming to aggravate the trouble. I put her on Peptenzyme, two tablets after each meal. I never saw a drug act so promptly nor so uniformly as has Peptenzyme. I do not believe there is another agent of its class on the market that approaches it in therapeutic value. I have also used the remedy in gastric and atonic dyspepsia with absolutely positive results. It does not wear out like many of the so-called digestive compounds, especially some of the stuff on the market that is sold to physicians at 25 cents per ounce, and which is composed principally of sugar of milk and other cheap agents to add bulk, with just sufficient pepsin to give them the characteristic smell. My advice to the profession is to use Peptenzyme whenever and wherever such an agent is indicated. In the vomiting of pregnancy it is sometimes

best to give one tablet one-half hour before eating, and one immediately afterwards. In indigestion, where there is malnutrition and consequently tissue waste without repair, Peptenzyme will act in a most agreeable and satisfactory manner. When given to the habitual drinker after a "booze," it will assist in correcting the gastric trouble and enfeebled nerve condition that almost robs him of a conscious individuality.—*Abstract from the Medical Council.*

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DR. OTTO SIMON, First Assistant in Professor Czerny's Surgical Clinic at Heidelberg, calls renewed attention to the severe intoxication which even minute quantities of cocaine may produce in predisposed individuals. In a neurasthenic, aged 24, death set in two minutes after injection into the urethra of  $1\frac{3}{4}$  drams of a 1 per cent. cocain solution. Since then Simon uses exclusively Beta-Eucain. It has entirely the same effect as cocain when administered in 0.6 to 0.9 per cent. saline solution at the body temperature; and in 1188 anesthetics a little headache and nausea was only encountered once, when the bladder was filled with 2 2-3 ozs. of a 4 per cent. solution, which vanished immediately when the bladder was washed out.

Eucain-Adrenalin is especially useful in the extirpation of subcutaneous or deep-seated tumors, lipomata, mammary adenomata and strumous lymphatic glands, for excision of tumors, cancers, and angiomata, and for minor operations around the head and face. For the extirpation of tubercular glands, and for Winkelmann's hydrocele operation, it may be used alone, or with Adrenalin. In chronic tubercular osteitis, ganglion, for the removal of foreign bodies, for tendon suture, and in operating ingrown toenails, Eucain should be used alone; and he also employed it for cystoscopies and litholapaxies.

For infiltration anesthesia he advises a warm 0.5 per cent. to 1 per cent. Eucain solution with 0.6 per cent. to 0.9 per cent. sodium chloride and 1:20,000 to 1:30,000 Adrenalin. Adrenalin strengthens the Eucain anesthesia, and has no undesirable effect in these dilutions.

Where applicable, Oberst's method, with 1 per cent. Beta-Eucain, is preferable to simple Eucain infiltration, and even to Eucain-Adrenalin.—*Abstracted from the Munchener Med. Wochenschrift, Vol. 51, No. 29, July 19, 1904.*

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NEW ORLEANS POLYCLINIC:—*Eighteenth Annual Session opens November 7, 1904, and closes May 20, 1905.* Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, including laboratory and cadaveric work.

For further information address, New Orleans Polyclinic, Post-office box 797, New Orleans, La.

## *Reviews and Book Notices.*

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MEDICAL RECORD VISITING LIST FOR 1905. William Wood & Co., Publishers, New York.

This "Visiting List" has always given the most complete satisfaction to all who have tried it.

A complete revision of the reading matter in the front part of the "List" has been made this year. The table of average doses has been carefully revised and brought up to date, all the newer drugs of importance being included. A novelty introduced last year for the first time into a "Visiting List" is the Obstetrical Chart. This will be found useful for making quick estimates of the probable duration of pregnancy. In all respects the high standard of manufacture, as to paper, printing, and binding, that has always distinguished the "Medical Record Visiting List" has been fully maintained.

MEDICAL NEWS VISITING LIST FOR 1905. Lea Brothers & Co., Philadelphia, Publishers. Price, \$1.50; with thumb-letter index, 25 cents extra.

This excellent annual publication comes to us with none of its former valuable details omitted. It contains thirty-two pages of data likely to be needed by every practitioner, and blanks for recording all details of practice, both clinical and financial. It is issued in four styles: weekly, dated for thirty patients; monthly, undated, for one hundred and twenty patients per month; perpetual, for thirty patients weekly and sixty patients undated, and without the preliminary data for those requiring specially large record books. The paper, binding, printing, etc. are of the best quality.

PHYSICIAN'S VISITING LIST (Lindsay and Blakiston's) for 1905. Fifty-third year of its publication. Seven different styles, ranging in price from \$1 to \$2.25. P. Blakiston's Son & Co., Publishers. Sold by all book-sellers and druggists.

With this edition "The Physician's Visiting List" enters upon the fifty-fourth successive year of its publication. This is a record which tells its own story. The old veteran is on hand. In addition to the other valuable features for which it is noted, we

wish to call attention to the pages on incompatibility, chemic, pharmaceutic, and therapeutic, and the page on the immediate treatment of poisoning. "The Physician's Visiting List" is a pocket record book and ever handy reference guide for the medical practitioner. Neat, compact, well-arranged, and durable, it has justly earned so many friends throughout the medical word that commendation is unnecessary.

**CRANIO-MUSCULAR ORIGINS OF THE BRAIN AND MIND.** By Philip H. Erbes, author of "Co-Origin of Organic and Inorganic Life," 12 mo, cloth, pp. 240, illustrated; price, \$1.20, postage, 10 cents. The Promethean Publisher, 622 N. Rockwell Street, Chicago, Ill., 1904.

The author does not claim this to be an exhaustive treatment of the evoluional origins of brain and mind, however the principles set forth in it are worthy of careful consideration. The chapters on emotion, consciousness, intellect, and that calling attention to the orderly reduplication of the spinal cord in the cerebral hemispheres, because of the original matter presented should claim special attention.

**VISITING AND POCKET REFERENCE BOOK FOR 1905.** The following is a comprehensive contents: Table of Signs and How to Keep Visiting Accounts, Obstetrical Memoranda, Clinical Emergencies, Poisons and Antidotes, Dose Table, Blank Leaves for Weekly Visiting List, Memorandum, Nurses Addresses, Clinical, Obstetrical, Birth, Death and Vaccination Records, Bills Rendered, Cash Received, Articles Loaned, Money Loaned, Miscellaneous, Calendar 1905, 126 pages, lapel binding, red edges. This very complete Call Book will be furnished by the Dios Chemical Co., of St. Louis, Mo., on receipt of 10 cents for postage.

**BLOOD - PRESSURE,** as Affecting the Heart, Brain, Kidneys, and General Circulation, by Louis Faugeres Bishop, A. M., M. D., Physician to the Lincoln Hospital, New York, etc., etc. 12mo, cloth, pp. 112. Price, \$1.00. E. B. Treat & Co., Publishers, 241-243 W. 23rd St., New York, 1904.

This is a most excellent little treatise on a very important subject, ably handled, and if its teachings are carefully studied and observed will not only rescue some of our young patients from early death, but will be the means of prolonging the lives and comfort of thousands of men advanced in years.



INTERNATIONAL CLINICS, A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, etc. etc., and other topics of interest to students and practitioners, by leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A. M., M. D., of Philadelphia. Vol. III, fourteenth series, 8vo, cloth, pp. 302. Price \$2.00 net. J. B. Lippincott Co., Publishers, Philadelphia, 1904.

The first one hundred pages of this splendid number of the International Clinics is taken up with most valuable articles on syphilis by some of the ablest syphilographers of the day; and the remainder is occupied by equally valuable lectures and original papers on treatment, surgery, medicine, gynecology, and neurology. In this connection we take pleasure in stating that at the Louisiana Purchase Exposition at St. Louis, the publishers, Messrs. J. B. Lippincott Company, of Philadelphia, were awarded the gold medal for the artistic design, quality of material, skill of workmanship, and literary excellence of their books and publications. Established in 1792, this firm is one of the very few which conduct every process of book-making under one roof.

TEXT-BOOK OF NERVOUS DISEASES AND PSYCHIATRY, for the use of students of medicine and practitioners, by Charles L. Dana, A. M., M. D., Professor of Nervous Diseases and *ad interim* Mental Diseases in Cornell University Medical College, Visiting Physician to Bellevue Hospital, Neurologist to the Montefiore Hospital, ex-President of the American Neurological Association, etc., etc. Sixth revised and enlarged edition, 8vo, cloth, pp. 690. Illustrated with 244 engravings and 3 plates in black and colors. Price, \$4.00, net. Wm. Wood & Co., Publishers, New York, 1904.

In this treatise the author has presented the science of neurology in a concise, and so far as possible, a complete form. Each subject has been taken, all the available facts regarding it have been ascertained, the writer's own experience has been collated, and with the data thus gathered the chapters have been written; supplying a very complete, practical, and concise work for both students and practitioners of medicine. The first part of the work

is devoted to diseases of the nervous system and brain, about equally dividing the six hundred pages of Part I, the remaining pages, about ninety, comprising Part II, being devoted to a consideration of mental diseases.

In his preface to the first edition, Dr. Dana says: "In the classification of nervous diseases and the description of their pathology, I have tried to apply the modern knowledge of general pathology as modified by bacteriology. This I have done conservatorily, yet not less than in my opinion is absolutely demanded. A good deal of havoc will be wrought eventually in our conception of the nature of nervous diseases by the newer pathological doctrines; yet I have made as little change as was consistent with undeniable facts."

Throughout the entire work we notice in this revised edition all the latest advances and most recent developments in nerve, brain, and psychical pathology and therapeutics.

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## *Selections.*

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THE CORRECTION OF ABNORMAL CONDITIONS OF THE BLOOD RELATIVE TO SURGICAL OPERATIONS.—Frequently the surgeon is called upon to operate on patients who, when they first present themselves, are in no condition to stand an operation on account of a deficient quantity of blood or the poorness of its quality. On the other hand, it is desirable that the patient regain his normal condition as soon as possible after operation, whether the abnormal condition of the blood is due to the operation or not.

The ideal remedy is that which will restore the normal condition of the blood in the shortest time with the least disturbance to the rest of the body, the digestive system particularly. Less necessary are palatability and cost of the remedy. To determine which of several preparations best fulfilled the above conditions was the purpose of this investigation.

All of the preparations used being recognized as good, Dr. A. J. Ochsner gave me permission to prescribe them as I saw fit to certain of his patients in Augustana Hospital. Only those cases were selected whose appearance indicated the need of a hematinic. As often as possible similar cases were paired off, one patient being given one preparation and the other patient another, and the results compared. The cases were paired according to pathological condition, age, sex, general condition, and the condition of the blood as to hemoglobin and erythrocytes at the beginning of treatment. The preparations used were malt with iron and manganese; malt with iron, quinine, and strychnine; Blaud's pills, and the preparation known as pepto-mangan (Gude).

After watching the effect of the medication on the patients, and observing the records, it is seen that Blaud's pills acted quickly, but constipated; the malt combinations caused nausea in a few patients, and the malt, manganese, and iron combination caused constipation in nearly all. The pepto-mangan, given in milk, was agreeable to take, and in no case did it cause nausea or constipation. While in two cases the Blaud's pills acted more quickly than pepto-mangan in two similar cases, on the whole the latter gave better and quicker results than any of the others, and at the same time caused no digestive disturbances in any of the cases.

Although the investigation was undertaken for the purpose of finding the best hematinic for surgical cases, it was tried in one case of chlorosis and in several obscure medical cases.

The following table shows the results obtained in all those cases where Gude's preparation was given. One to four drams were given in milk to each case, three times a day. The hemoglobin was estimated with Von Fleischel's hemometer, and the erythrocyte count made with the Thoma-Zeiss apparatus. The first blood count was made previous to operation in all surgical cases, and the last a short time before the patient's discharge from the hospital. The second count was never made immediately after the operation because of the temporary derangement due to the anesthetic and the loss of blood:

NAME	Age	DIAGNOSIS	DATE	Erythrocytes per 1 c. c.	Per cent of Hemo globin
1. G. N. .... (incurable.)	53	Carcinoma of stom- ach.	9-29-03	2,920,000	33
			10-12-03	3,400,000	43
			10-25-03	3,260,000	42
			11 -8-04	2,520,000	36
2. Mr. L. .... (incurable.)	49	Carcinoma of stom- ach	10-29-03	2,665,000	27
			11-23-03	2,900,000	28
			12- 5-03	2,540,000	27
			12-19-03	2,300,000	26
3. Miss J. ....	17	Acute menorrhagia.	12- 4-03	2,310,000	36
			12-20-03	3,565,000	44
			12-27-03	4,160,000	49
4. Mrs. E. K. ...	33	Menorrhagia.	12- 7-03	4,340,000	44
			1-10-04	3,565,000	64
			1-18-04	5,100,000	82
5. Mr. S. ....	23	Neurasthenia (?)	12-16-03	4,060,000	60
			1- 7-04	4,260,000	65
			1-14-04	4,560,000	75
6. Mr. K. ....	35	Tuberculosis of mes- enteric glands.	11-15-03	3,825,000	62
			12-10-03	4,826,000	68
			1- 4-04	4,716,000	66
7. Mrs. F. ....	23	Pelvic abscess	10-25-03	4,006,000	60
			11-23-03	5,100,000	69
			12-11-03	4,975,000	78
8. Mrs. A. ....	34	Pelvic abscess	12-10-03	3,195,000	53
			12-29-03	4,293,000	58
			1-11-04	4,560,000	78
9. Miss A. J. ...	16	Chlorosis.	10-25-03	3,010,000	45
			11-12-03	4,950,000	65
			11-28-03	5,676,000	80
10. Mrs. H. ....	40	Myoma of uterus.	7-15-03	2,100,000	42
			8-17-03	3,900,000	55
			9-15-03	4,500,000	80
11. Johnny L. ...	13	Tuberculosis of hip	12- 1-03	2,680,000	45
			12-29-03	3,600,000	55
			1-20-04	4,100,000	62
12. Mr. E. P. ...	21	Tuberculosis of ankle.	10-29-03	4,310,000	66
			11-10-03	4,850,000	71
			1-23-04	5,166,000	75
13. Johnny F. ...	9	Extensive burn and infection of sur- face.	11- 9-03	3,560,000	50
			11-25-03	3,900,000	56
			1-23-04	4,362,000	68

14. Miss E. B...	17	Perforative appen- dicitis.	11-25-03	3,600,000	55
			12-26-03	4,000,000	65
			1-22-04	4,250,000	69
15. N. N.....	29	Suppurative appen- dicitis.	12-20-03	4,200,000	60
			1- 2-04	4,400,000	66
			1-20-04	5,120,000	75
16. Mr. B.....	28	Chronic appendici- tis.	1- 2-04	3,565,000	62
			1-10-04	4,320,000	70
			1-23-04	4,800,000	78
17. Mr. S.....	37	Gangrenous appen- dicitis.	10-10-03	3,300,000	45
			10-27-03	3,350,000	45
			11-27-03	3,010,000	40
18. Miss W. J...	29	Empyema.	11-20-03	2,740,000	44
			12-20-03	3,070,000	52
			1-22-04	3,820,000	60
19. Mr. F.....	44	Cholelithiasis. Chronic appendi- citis.	11-23-03	3,560,000	57
			12- 4-03	4,100,000	68
			1-12-04	4,640,000	78

In the nineteen cases tabulated there is an average increase of 800,000 erythrocytes and of 14.5 per cent. hemoglobin. This improvement was during forty days on an average. The usual time a patient stays in the hospital is twenty-one days, when the case is of ordinary severity from a surgical standpoint. Such cases were placed on tonic treatment and showed rapid improvement, but of such cases only one (Case 16) is noted, because it might be urged they would improve equally fast with or without a tonic.

It is seen from the above table that even in the cachexia of carcinoma there is a temporary improvement, which shows that in the use of this tonic we are dealing with a powerful hematinic. In Case 17 there was no improvement, the patient dying shortly after the last count. At the autopsy I found a pyogenic abscess in the liver as large as an orange, and about 200 c.c. of pus below the right kidney, which explained the retrogression. In all of the other operated cases the improvement was steady and marked, especially in uterine diseases accompanied by loss of blood. In the case of chlorosis (Number 9) the improvement was remarkable, the patient being discharged cured in a little over a month, at which time all the symptoms had disappeared.—*Medical News*, Sept. 2, 1904.

**THE TREATMENT OF INFANTILE SYPHILIS.**— When the mother or father is known to be syphilitic, treatment should be begun as soon as pregnancy is determined. A mild mercurial and iodid treatment of the mother not only interferes in no way with the course of gestation, but is our best guarantee for the viability of the child and for its future cure.

If there has been no opportunity for antenatal treatment, it should be begun immediately after birth under the above circumstances, even if the child at the moment shows no trace of the hereditary taint. If it is breast-nourished, two courses are open to us. The specific medication can be administered to the mother, to reach the child through the milk, or it can be given directly to the infant itself.

As regards the first method, it has been doubted whether mercury is excreted in the milk, though the iodids undoubtedly are. Nevertheless, practical experience shows that syphilitic infants thus treated do improve and recover; and since the mother, though she may show no signs of the disease, is immune to a fresh infection, she is undoubtedly syphilitic, and will therefore be benefited by treatment. My first care, therefore, is to put the mother of the child on the approved treatment for her disease.

The heredo-syphilitic child, however, almost always requires more intensive medication than can be gotten in this way alone. The hypodermatic administration of mercury, the method of election for adults, is too severe and too troublesome for infants; I have used it in only a few of the worst cases, when other methods were too slow. Oral administration, also, is undesirable as a rule; the infantile gastro-intestinal tract is readily seriously deranged, and we may easily do the patient more harm than good. I limit medication by this method to the sustentation of other measures when required by the administration of mercury with chalk in  $\frac{1}{4}$  to 1 grain doses three times a day. This preparation is itself non-irritating and anti-diarrhoeal, and most infants take it with benefit.

The infantile skin, being extremely delicate and more absorptive than that of adults, affords a ready avenue for the introduction of the specific drug into the system. Inunctions of the ordinary type are inapplicable, since they are almost certain to cause

troublesome inflammatory reaction and eczema. Nor are they required. The mere application of the mercurial in suitable vehicle to the skin suffices to occasion cutaneous and respiratory absorption in amount sufficient for therapeutic effect. If the case is a mild one, half a dram of white precipitate ointment made with lanoline can be spread on a cloth, worn next to the skin under the belly-band, and changed twice daily. A varying proportion of ordinary mercurial ointment can be added if therapeutic action seems too slow; and in children one year old the pure mercurial ointment may be used. I do not find that the newer mercurial preparations so extensively advocated of late offer any advantages of importance.

For severer cases of infantile syphilis, and more especially those with extensive dermal lesions, I prefer the mercurial baths. Ten to twenty grains of the bichlorid are dissolved in an ordinary wooden wash tub of warm water; the child is immersed therein once or twice a day, care being taken that none of the fluid reaches the face, for ten or fifteen minutes. In a few recent cases I have used sublamin, which is as effective and less irritant, in the place of the corrosive chlorid; half a dram may be used for each bath. It has been claimed that only a local effect can be expected from these baths; but the results show that it is a perfectly effective and reliable means of general treatment.

The iodids are required, of course, in the later stages of infantile syphilis. If the child is still nursing they can be administered through the mother's milk; if not, they must be given directly to the infant, by mouth. Fortunately children stand the iodid of sodium well, and as large doses as 15 or 20 grains three times daily can readily be administered.

Local lesions can be to a large extent prevented by scrupulous cleanliness and careful treatment of any inflammatory conditions that may appear. Proper bathing; care of the mouth and nares, with the use of a tannin-glycerin mouth wash; avoidance of irritation from the excreta, with the free use of a starch or other bland powder; these are essential parts of the treatment of every case of infantile syphilis. Nitrate of silver, 10 grains to the ounce, for mucous patches, and a 10 per cent. solution of the oleate of mercury in oleic acid for the nose are effective.

For condylomata and moist papules I use calomel freely, usually diluted with an equal amount of powdered starch. This powder is an excellent local application for any of the dermal lesions that require special attention, and particularly for the vesicular and pustular ones after evacuation of their fluid, and for ulcerations. It is usually better for the infantile skin than the various mercurial ointments.

As regards the length of time for which treatment should be continued there is no certain rule. It should be begun as early as possible; before birth, as I have said, if the presence of luetic contamination is known. It should be conducted exactly as in the acquired form of the disease, with intermissions for three years, and as long thereafter as symptoms persist. After one year of entire freedom from any symptoms of the disease, treatment may be stopped; but the patient should be kept under observation for a number of years thereafter, and a vigorous course of treatment instituted immediately upon the appearance of any signs of a recrudescence of the disease.—*Prof. William S. Gottheil, M. D., in Archives of Pediatrics.*

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RUPTURE OF THE UTERUS DURING LABOR.—T. B. Grimsdale (*British Journal Obstet.*, December, 1903) finds that its frequency varies, according to various authorities, from 1 to 482 cases to 1 to 6,000. The mortality is also very high, varying between 55 and 95 per cent., according to the estimates of authorities. The lowest mortality is obtained where prompt abdominal operation can be performed. A patient who came under the writer's observation had four children and her fifth confinement started on June 14, 1903, at 2 P. M., when the "waters" burst. At 9:30 the following evening labor pains began, and continued until a hand (the left) presented. Version was done, but as the os was rigid there was some delay. The child was dead and putrid. When the operator tried to get the foot down through the os, it was recognized that something was wrong, for at the posterior portion of the os another opening could be felt, and through this there came what the accoucheur considered a loop of the intestines. The delivery was completed and after the vagina had been packed with gauze, the patient was removed to



the Royal Infirmary, where she arrived at 3 o'clock the next morning. The abdomen was opened as soon as possible, and there escaped from this cavity clear fluid and blood clots.

The uterus was found to be ruptured in the posterior portion of the lower uterine segment. Panhysterectomy was performed. The patient was much collapsed after the operation. On June 28, one week after the operation, the patient acquired pleurisy, which cleared up in four days, and on July 21 she was discharged as cured. He believes that the safest treatment in the long run will be found in the boldest measures; also, that it is safest in these cases to remove the entire uterus.—*Medical Sentinel*.

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DYSPEPSIA INTESTINALIS ACIDA LACTARUM.—Jan Raczynski (*Wein. klin. Wochenschr.*, March 16, 1903) describes this disease of nurslings fed entirely on breast milk, as consisting of restlessness, vomiting, meteorism, and diarrhoea. The stools contain whitish clumps, as well as green and grass-green lumps. The condition may last for weeks or months and may disappear without treatment. It may interfere with the child's nutrition or with its development. The author goes into detail as to the etiology, laying especial stress upon the chemical changes taking place in the ingested milk. The stools are much more acid than normally, and this is due, not to chemical change, but to the excessive growth of the normal intestinal bacteria which is sometimes seen in diseased conditions. Occasional feeding with cow's milk is the most efficient form of treatment.—*New York Medical Journal*.

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MEDICAL ORGANIZATION.—We trust that our recent graduates, who have gone to take their places in doing the work and carrying the burdens of the profession, will devote some thought to the subject of this brief article. The man who enters the medical profession to-day, safeguarded as it is by proper legislation, equipped with excellent schools, given in some degree its proper place as a factor in the community, does not always realize that these things have not come of their own accord, but have resulted from the earnest and continuous efforts of his elder colleagues and their predecessors. The newcomers who fall heirs

to the present state of the medical profession, social, political, and scientific, owe a duty to that profession—to keep at least undiminished its present possessions and to add as much as may be proper and possible in each and every direction.

Graduate of 1904, join your county or parish, your State, and finally the National Society as the first step in the performance of this duty. Without organization very little is ever accomplished. Remember, too, that in thus doing your duty to the profession you will place yourself in the most advantageous position for doing your duty to yourself and to your patients. You learn much that is valuable by rubbing against your co-laborers, at the same time that you contribute to their acquisitions of medical lore. Again, your close acquaintance with them will give opportunities for co-operation to mutual advantage and eliminate unnecessary friction. Propinquity, they say, is the best matchmaker; it might be added that it is essential to friend-making.

Send in your application for membership in your local society and then go on up through your State Society into the American Medical Association, without membership in which you ought to be unwilling to rest satisfied.—*The Phagocyte*.

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NEW METHOD OF INTESTINAL UNION.—Horsley (*Annals of Surgery*, Nov., 1903) describes his operation as follows:—

Intestinal clamps are placed, the mesentery is incised, and if need be, resected. The forceps that clamp the vessel are also made to include both layers of peritoneum as they separate from the mesentery to encircle the bowels. The tissue within the bite of the forceps is ligated with fine silk so covering the bowel, which is usually devoid of peritoneum. The bowel is then divided and the cortex borders placed in contact and held there with forceps. Both walls of the intestines are now transfixed with No. 2 braided silk, about half way between the mesenteric insertion and the forceps. This is tied. Part of the intestinal walls forming a crescentic area, the center of which is held by the forceps, is now cut out, and the cut edges sutured through and through. The needle is then thrust directly through the intestinal wall close to the right of its last puncture and emerges

from the serosa. The character of the stitch is now changed to a Cushing right angle continuous suture, penetrating all coats, and inverting the margins. Firm traction is maintained on the thread. When the first knot is reached it is invaginated and the suture continued by two more insertions of the needle. After this suturing is completed, scarcely any of the thread can be seen. The mesentery is then sewed up with a continuous suture. Nineteen dogs were operated upon by this method without a death.

Evans has demonstrated that the danger from stricture following intestinal resection is overrated. Owing to the excision of the crescentic area, the diameter of the intestine at the point of union is greater than its normal size. He believes the continuous suture is by all odds preferable to the interrupted. The operation can be done in eight minutes. The results of hydrostatic pressure on the unions obtained by this stitch, show that a suture through all coats is stronger during the first six days than one including submucosa only. The Connell method stands more pressure at the end of the first and the sixth day, the new method stands as much as the Connell during the critical time of intestinal union, which is the third and fourth days.—*Medical Sentinel*.

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FICKER'S TYPHOID TEST.—Ficker (*Berliner Klinische Wochenschrift*, No. 45, 1903) has proposed the following procedure as equally accurate, and on account of its simplicity, much preferable to the Gruber-Widal test. The material required is as follows: Ficker's test fluid, a fluid containing dead typhoid bacilli obtained from a culture of known origin and virulence, normal salt solution, graduated pipette, cupping glass, and three test tubes. The test fluid with the apparatus in convenient package may be had of E. Merck. Blood serum is diluted with normal salt 1 : 10, test tube No. 1 receives 0.2 c. c. of this diluted serum, No. 2, 0.1 c. c. To No. 1 add 0.8 c. c. of the test fluid, to No. 2, 0.9 c. c., No. 3, 1 c. c., but no serum for control, cork, shake, and stand in a dark place ten to fourteen hours, examine by transmitted light, shaded background (hand) advised. Positive reaction is shown by clearing of fluid and clumping of bacilli.

J. Meyer (*Berliner Klinische Wochenschrift*, No. 7, 1904) has tested Ficker's fluid in ten cases and sums up his results as follows: "The use of Ficker's typhoid test not only leads to the same results as the Gruber-Widal test, but, from theoretical and practical considerations, is to be preferred to it and should be recommended to practitioners and clinicians." — *Colorado Medical Journal*.

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AN ANTENATAL CASE OF MEASLES.—J. R. Gibson (*The Lancet*, October 31, 1903) reports the case of a woman attended in a third and normal confinement. The nurse when washing the child called attention to some dull red spots on the buttocks. A suspicion was entertained of a syphilid, but no opinion was expressed, as the two previous children were very healthy and the character of the parents was above reproach. On the next morning the uncertainty was cleared up, for the author found the child covered with a typical measles rash and suffering from suffusion of the eyes, nasal catarrh, and bronchitis, and, in short, all the cardinal symptoms of measles. The child recovered in the usual period and without any medicinal treatment. The temperature ranged from 99° to 100° F. The mother made an uninterrupted recovery and showed not a single symptom of measles. When the baby was eight months old the other two children took the measles, but the baby did not. The mother had had measles when a child.—*Journal American Medical Association*.

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ADENOID VEGETATIONS AND ALBUMINURIA.—G. Carrière has on several occasions observed the coexistence of albuminuria and adenoid vegetations. An enormous microbial growth occurs in connection with these vegetations. The microbes which live in the anfractuosités may pass into the current of the circulation and secondarily infect the organism or secrete toxins. In both cases the kidney is irritated.

When albuminuria is found in a child and can be explained in no other way, it is well to remember that it may depend upon the presence of vegetations. It may even be asked if certain cases of nephritis of which the cause is not obvious have not been produced by overlooked vegetations.—*La Tribune Médicale*.

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